Barclays Official

CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Complete Title

(continued)

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§ 1806. Intent.

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1. Repealer of chapter 4 (subchapters 1–9, sections 1806–1919, not consecutive) and new chapter 4 (articles 1–8, sections 1806–1915, not consecutive) filed 3–10–83; effective thirtieth day thereafter (Register 83, No. 11). For prior history, see Registers 77, No. 20, and 73, No. 27.
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Chapter 5. Insurance Commissioner

(Originally Printed 5–15–46)

Subchapter 1. Production of Insurance

Article 1. Standards for Approval and Disapproval of Names of Insurance Producers

§ 2050. Authority.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Section 790.10 of the Insurance Code.

NOTE: Authority cited: Section 790.10, Insurance Code.

HISTORY

1. Repealer of Article 1 (Sections 2050–2052) and new Article 1 (Sections 2050–2052.3, not consecutive) filed 8–17–73; designated effective 10–1–73 (Register 73, No. 33). For former Article 1, see Register 71, No. 48.

§ 2050.1. Purpose.

California Insurance Code Section 1724.5 provides that the Commissioner may, in writing, disapprove the use of any true or fictitious name (other than the bona fide natural name of an individual) by any licensee on any of the following grounds:

(a) Such name is an interference with or is too similar to a name already filed and in use by another licensee;

(b) The use of the name may mislead the public in any respect;

(c) The name states or implies that the licensee is an insurer, motor club, hospital service plan or entitled to engage in insurance activities not permitted under licenses held or applied for;

(d) The name states or implies that the licensee is an underwriter. This subdivision shall not prevent a natural person who is a life licensee from describing himself as an "underwriter" or from using the designation "Chartered Life Underwriter" if entitled thereto nor shall it prevent a natural person who is a fire and casualty licensee from using the designation "Chartered Property and Casualty Underwriter" entitled hereto nor a producers trade association each member of which is also separately licensed from having a name containing the word underwriter; or

(e) The licensee has already filed and not discontinued the use of more than two names including the true name. This subdivision shall not event a licensee who has lawfully purchased or succeeded to the business or businesses of other licensees from using for each such business not more than two additional names, true or fictitious, consisting of names used by his predecessors in the conduct of such businesses.

The purpose of these regulations is to promulgate the criteria whereby the Commissioner disapproves an application for name approval filed by or on behalf of an applicant or licensed producer and to set forth the Commissioner's interpretation of the terms and provisions appearing in subsections (a), (b), (c), (d), and (e) of Section 1724.5 of the Insurance Code, and to specify a list of words or phrases that shall serve as the grounds for disapproval if used (or in some cases if used improperly) in a producer's name. The list of such words and phrases appearing in these regulations is representative only and is intended to serve as a standard or guideline and shall not be construed as the only words or phrases which when used, or when used improperly, would be misleading or would have the capacity or tendency to mislead the public in any respect. Subsections (d) and (e) of Section 2052.4 of these regulations will be amended from time to time as conditions warrant the revision of the list of objectionable words and phrases.

§ 2051. Definitions.

For the purposes of this Article and Division 1, Part 2, Chapter 5, Article 12, of the Insurance Code, the following definitions shall apply:

(a) The term "producer" means any person (including any partnership, association or corporation) licensed by the Commissioner in one or more of the following capacities: insurance agent, variable contract agent, life and disability agent, life only agent, disability only agent, insurance broker, surplus line broker, special lines surplus line broker, bail agent and bail permittee (The term "producer," for the purpose of these regulations, does not encompass or mean persons licensed as insurance solicitors or bail solicitors because an individual licensed as either an insurance solicitor or bail solicitor is authorized to do business solely under the said individual's true name or under the name(s) appearing on the license of the said individual's employer.);

(b) The term "true name" means present legal name or true corporate name;

(c) The term "bona fide natural name" means the name given an individual at birth or adoption during minority;

(d) The term "fictitious name" means any name other than a true name or a bona fide natural name;

(e) The term "applicant" means a person applying for approval of a name, and

(f) The term "other applicant or licensee" or "another applicant or licensee" shall include all persons except the applicant required by the Insurance Code:

(1) To hold a license from the Insurance Commissioner;

(2) To hold a certificate of authority from the Insurance Commissioner; or

(3) To have a name approved by the Insurance Commissioner although not otherwise required to be licensed.

§ 2052. Interference with a Name Already in Use or Under Reservation.

Except for the bona fide natural name of an individual, no name proposed by an applicant or licensed producer shall be approved if such name is an interference with a name already approved for use by another applicant or licensee of the Department of Insurance.

§ 2052.1. Proposed Name Too Similar to Name Already in Use or Under Reservation.

Except for the bona fide natural name of an individual, no name proposed by an applicant or licensed producer shall be approved if such name is too similar to a name already approved for use by another applicant or licensee of the Department of Insurance. Similarity is determined by comparing the first two, or more, words, initials, and/or numbers in the proposed name, with any or all of the words, initials, and/or numbers of all existing approved names.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Section 1724.5, Insurance Code.

HISTORY

1 Amendment of section and new NOTE filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2052.2. Proposed Name States or Implies Insurance Capabilities Not Permitted Under Held or Applied for Licenses.

No true or fictitious name proposed by an applicant or licensed producer shall be approved if such name states or implies, or would lead reasonable persons to infer, that the applicant or licensed producer is an insurer, motor club, hospital service plan, or other entity entitled to engage in insurance activities which in fact are not permitted under held or applied for licenses. This rule is intended to apply to names which are objectionable in and of themselves and, therefore, this rule shall apply whether or not the name proposed for use by an applicant or licensed producer would interfere with, or would be too similar to, a name already approved for use by another applicant or licensee.

§ 2052.3. Proposed Name States or Implies Ability to Act as an Insurer or Guarantor.

No true or fictitious name proposed by an applicant or licensed producer shall be approved if such name states or implies, or would lead reasonable persons to infer, that the applicant or licensed producer is an underwriter (i.e., an insurer or guarantor). This section, however, does not prohibit any agent from indicating that such agent is an authorized representative of an admitted insurer if such agent is also clearly designated as an agent representing such insurer or a natural person otherwise entitled to do so from using the title "Chartered Life Underwriter" (CLU) or "Chartered Property and Casualty Underwriter" (CPCU), and no approval from the Commissioner is required for the use of such association, wherein each member of the association is also separately licensed, may use the word "underwriter" in the name under which the association is licensed.

§ 2052.4. When Proposed Name Is Misleading.

No name proposed by an applicant or licensed producer (other than the bona fide natural name of an individual) shall be approved if it appears that use of the proposed name may mislead the public in any respect. When the true name of an organization is disapproved under these regulations, said organization may operate under an approved fictitious name provided that a commitment to use said approved fictitious name exclusively in the solicitations of insurance is made by the applicant or licensee to the Commissioner. A disapproval under this section may be based on one or more of the following criteria:

(a) The name is the same as, closely resembles, borrows on the name of, or implies affiliation with or sponsorship by, a federal, state, or local governmental authority or program.

(b) The name is the same as the name of a well–known company, or is so similar in spelling, pronunciation or appearance to the name, trade name, trademark or service mark, logo, or symbol of a well–known company as to borrow on the name of, or imply affiliation with, the said well–known company. This rule shall apply whether or not the company or business entity that would suffer the infringement is licensed by the Insurance Commissioner or regulated by the Department of Insurance, or is otherwise identified with the insurance industry.

(c) The name fails to state or clearly indicate that the applicant or licensed producer is or will be an insurance producer by any of the following:

(1) Failing to include in its name the word "insurance" followed by one of the following definitive words:

(A) "agency", "services", "marketing", "sales", "solutions", "center";

(B) "broker", "brokers", or "brokerage", as long as the applicant or licensed producer holds broker–authority and has a broker's bond on file with the Commissioner; or,

(C) "associates", as long as the applicant or licensed producer is applying for a business entity license.

(2) An administrator or applicant for an administrator certificate that fails to include one of the following words in its name: "administrator", "administrative", or "administration".

(3) A bail applicant or bail licensee that fails to include the word "bail" in its name.

(d) The name states or implies, or would lead reasonable persons to infer:

(1) That the applicant or licensee is primarily engaged in some line of business other than the insurance business, and the applicant cannot qualify for any of the exceptions set forth in paragraphs (2), (3), and (4) of this subsection.

(2) That the applicant or licensee has expertise in the area of investment, tax shelter, financial or estate planning or computer programming. An applicant may overcome this objection by showing that he qualifies under either of the two following exceptions:

(A) An exception to this rule may be made on a case by case basis where the applicant or licensee holds a certificate as a broker\dealer under California Corporations Code Section 25210 and/or where applicant holds a certificate as an investment adviser under the provisions of California Corporations Code Section 25230, and applicant has submitted evidence satisfactory to the Commissioner that in excess of 80% of applicant's net income from the said business entity for which name approval is being sought is derived from sources of business other than insurance. The foregoing exception is not available to an agent of a broker–dealer, as the word "agent" is defined in California Corporations Code Section 25003.

(B) An exception to this rule may be made on a case by case basis where a licensee is seeking approval for the use as a corporate name the same name, whether true or fictitious, in which he is licensed as an unincorporated producer, provided the said licensee is an officer owning 10% or more of the shares of the corporate applicant for license. The foregoing exception, however, shall not be available to an applicant or a licensee who purchases the unincorporated business or businesses of another licensed producer subsequent to the adoption of these regulations.

(3) That the applicant or licensee is a regulated finance or mortgage company. An exception to this rule may be made where the applicant presents evidence satisfactory to the Commissioner that applicant's principal business is that of a regulated finance or mortgage company and that 80% of applicant's net income from said business entity is derived from sources of business other than insurance or where the applicant presents a verified statement to the effect that insurance coverage will be written only on those persons who are customers of the finance or mortgage company generally identified with the name for which approval is sought. This exception to the rule shall apply whether the applicant is a regulated finance or mortgage company or is held or controlled by a regulated finance or mortgage company.

(4) That the applicant or licensee is engaged in any other business activity, including but not limited to retail sales or benefits consulting. An exception to this rule may be made where the applicant presents evidence satisfactory to the Commissioner that applicant's principal business is that of retail sales having nothing to do with insurance and that 80% of applicant's net income from said business entity is derived from sources of business other than insurance or where the applicant presents a verified statement to the effect that insurance coverage will be written only on those persons who are customers of the retail business generally identified with the name for which approval is sought. This exception to the rule shall apply whether the applicant is the said retail business entity or is held or controlled by such business entity.

(e) The name makes use of one or more of the following words or phrases in its singular or plural form or a derivation of one or more of such words or phrases:

(1) "A," singly or in a series of such capital letters as the initial part of a name;

(2) "Advisor";

(3) "Analyst," unless the licensee holds or is applying for a Life and Disability Analyst License;

(4) "Assigned Risk";

(5) "Assurance Company" or "Assurance Corporation" or "Assurance, Inc.";

(6) "Bureau";

(7) "Cal–Med";

(8) "Citius Altius Fortius";

(9) "Compensation";

(10) "Consultant";

(11) "Consumer";

(12) "Counselor" or "Counsellor";

(13) "Credit unless the licensee is a Credit Union";

(14) "Department";

(15) "Deposit Insurance";

(16) "Excess", unless the licensee holds or is applying for a Surplus Line Broker license;

(17) "E&S", unless the licensee holds or is applying for a Surplus Line Broker license;

(18) "Federal";

(19) "Government";
(20) "Indemnity";
(21) "Institute";
(22) "Insurance" when comprising the last word (e.g., Great Cliff Insurance) or preceding "Company" or "Corporation" or "Incorporated" or "Inc.", or "Limited" or "Ltd", or "Limited Liability Company" or "LLC", or "Limited Liability Partnership" or "LLP";
(23) "Insurer";
(24) "Insuror";
(25) "Investment";
(26) "Investor";
(27) "Life" when comprising the last word (e.g., Acme United Life);
(28) "Medi" when used as the first part or prefix of a word (e.g., Medical, Medi-Cal, Medifund, Mediplan, and similar combinations);
(29) "Mortgage Guarantee" or "Mortgage Guaranty";
(30) "National";
(31) "Nationwide" (except when an agent representing an insurance company whose name contains the word "Nationwide" and the agent is authorized by said company to use the word to identify with such insurer);
(32) "No Fault";
(33) "Olympic";
(34) "Olymiad";
(35) "Plan";
(36) "Reinsurance", unless the licensee holds or is applying for a Reinsurance Intermediary–Broker or Reinsurance Intermediary–Manager license;
(37) "Reserve";
(38) "Social Security";
(39) "State";
(40) "Statewide";
(41) "Trust";
(42) "Underwriter";
(43) "United States," "U.S." or "U.S.A.";
(44) "Veteran."

(f) The name *improperly* makes use of one or more of the following words or phrases in its singular or plural form or a derivation of one or more of such words or phrases:
(1) "Administrator";
(2) "Advocate";
(3) "Affordable";
(4) "Asset";
(5) "Associate";
(6) "Broker";
(7) "California";
(8) "Care";
(9) "Cash";
(10) "Certified";
(11) "Cheap";
(12) "City";
(13) "Company";
(14) "Consolidate";
(15) "Cost";
(16) "County";
(17) "Discount";
(18) "Education";
(19) "Elder";
(20) "Enterprise";
(21) "Entitlement";
(22) "Equity";
(23) "Estate";
(24) "Expert";
(25) "Franchise";
(26) "Group";
(27) "Legal";
(28) "Long Term Care";
(29) "Money";
(30) "Mature";
(31) "Price";
(32) "Protection";
(33) "Provider";
(34) "Retire";
(35) "Safe";
(36) "Secure";
(37) "Securities";
(38) "Senior";
(39) "Specialist";
(40) "Tax";
(41) "Transcontinental."

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Section 1724.5, Insurance Code.

HISTORY

1. Amendment of section and new NOTE filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2052.5. Effective Date of Standards.

The standards established by these regulations are applicable to names filed with the Insurance Commissioner on and after October 1, 1973, the effective date of these regulations. Producers may continue to use the name(s) under which they are licensed on the effective date of these regulations. The adoption of these regulations does not affect the authority of the Commissioner to order a producer to discontinue the use of a name on any of the grounds specified in Insurance Code Section 1724.5; provided, however, that any such action by the Commissioner shall be conducted in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code.

Article 2. Bail Transactions

PRELIMINARY

§ 2053. Application; Construction.

This article as amended is applicable to all applications for licenses filed after the effective date of such amendments, to all transactions or severable portions thereof occurring thereafter and to the keeping of all records pertaining to such transactions or severable portions thereof. All such applications filed prior thereto and all transactions or severable portions thereof occurring prior thereto and the keeping of records pertaining thereto shall be governed by the provisions of this article which were in effect prior to such date. Insofar as the provisions of this article are substantially the same as the provisions of this article as it read prior to said effective date, they shall be construed as restatements and continuations thereof and not as new provisions.

NOTE: Authority cited for Article 2 (§§2053–2104, inclusive), Section 1812, Insurance Code. Reference: Sections 1800–1822, California Insurance Code.

HISTORY

1. Repealer of Article 2 (§§2055–2102, inclusive) filed 11–30–53, designated effective 1–1–54; new Article 2 (§§2053–2104, inclusive) filed 11–30–53, designated effective 12–1–53 as therein specified (Register 53, No. 22).
2. Repealer of 2053,2053.1 and 2053.2 filed 12–11–53 as an emergency; designated effective 1–1–54; new §§2053, 2053.1 and 2053.2 filed 12–11–53 as an emergency; designated effective 1–1–54 (Register 53, No. 22).
3. Repealer of Article 2 (Sections 2053–2104) and new Article 2 (Sections 2053–2104) filed 9–12–77; effective thirtieth day thereafter (Register 77, No. 38).

§ 2053.1. Past Violations; Power of Commissioner.

Insofar as the provisions of this article are new provisions, their promulgation shall not preclude the commissioner from taking such action as is permitted law for acts or omissions which occurred prior to the effective date these amendments.

§ 2054. Definitions; Application of Insurance Code.

Insofar as they are applicable, the definitions contained in the General Provisions and in Chapter 7, Part 2, Division 1 of the Insurance Code are applicable to this article.

§ 2054.1. "Bail License"; "Bail Licensee"; Terms Defined.

As used in this article "bail license" includes all licenses specified in Section 1801 of the Insurance Code and "bail licensee" the holders thereof whether on a permanent or temporary basis and whether as individuals or as members of a partnership.

§ 2054.2. "Bail Agent" or "Permittee" Includes Copartners.

Whenever the term "bail agent or permittee" is used in this article, such term includes the members of a partnership of bad agents or permittees if applicable.

§ 2054.3. "Bail"; "Transaction of Bail"; Terms Defined.

As used in this article "bad" or "transaction of bail" includes undertakings of bail and "bail bond" as that term is defined in Insurance Code Section 1800.4, including the activities in respect to execution or delivery of undertakings of bail of any person, whether designated "general agent" or otherwise, who conducts, or supervises the conduct of bail business pursuant to contract with a surety insurer.

§ 2054.4. Payment of Commissions; Unlawful Rebates; Prohibited.

No person may receive commission on bail or the transaction of bail as defined in Section 2054.3 unless he holds a bail license as defined in Section 2054.1. No bail licensee shall pay or allow in any manner, directly or indirectly, to any person who is not also a bail licensee any commission or other valuable consideration on or in connection with a bail transaction. This section shall not prohibit payments by a bail licensee to an unlicensed person of charges such person for services of the kind specified in Section 2081(c) and (d).

§ 2054.5. "Arrestee" Defined.

As used in this article "arrestee" means any person actually detained or subject to detention in custody whose release may lawfully be effected by bail.

§ 2054.6. Notices; Time for Filing.

Whenever any provision of this article requires that notice be given to or that filing be made with the commissioner a specified period of time before a matter may lawfully be used or an event lawfully occur, such period of time may be reduced by the commissioner at the request of the licensee if good cause is shown therefor.

§ 2054.7. Notice of Noncompliance; Request and Hearing.

Whenever pursuant to any provision of this article the commissioner gives notice to any person that such person may not establish a particular relationship or perform a particular act, such person shall upon written request therefor filed within 10 days of said notice be granted within 60 days following the date of such notice on the issues of noncompliance specified in such notice. Whenever pursuant to the provisions of this article the commissioner gives notice to any person to discontinue within a specified time a particular established relationship or the performance of a particular act, such person shall upon written request therefor filed within 10 days of said notice be granted a hearing on the issues of noncompliance specified in such notice which shall big held at least 10 days prior to the date specified in the notice as the date such person shall discontinue the relationship or the act.

LICENSE REGULATIONS

§ 2055. Applications; Forms.

All applications for original or renewal bail licenses shall be on forms furnished by the commissioner. All applicants for such licenses and all bail licensees shall furnish such supplementary information and supporting statements as the commissioner may require.

§ 2056. License Qualifications.

An original bail license shall not be issued to any person unless he:

(a) Is a California resident and has been such for a period of two years immediately preceding issuance of the license.

(b) Satisfies the commissioner that he is a person of good business reputation and of good general reputation in:

(1) The community in which he intends to principally engage in the transaction of bail, or

(2) The community or communities in which he formerly resided, if he has not been a resident of the community in which he intends to principally engage in the transaction of bail for a sufficient period of time to establish such reputation.

(c) Is 18 or more years of age.

§ 2057. Prohibited Associations.

An original or renewal bail license shall not be issued to any person nor shall it be kept in force if he is:

(a) Regularly or frequently employed by or associated with:

(1) A court of law in respect to its exercise of its criminal jurisdiction, if any,

(2) A public law enforcement agency possessing the power of arrest and detention of persons suspected of violating the law in the specific terms of the statutes establishing and governing the agency.

(b) A private patrol operator.

(c) An active member of the State Bar of California.

(d) An associate of persons of bad general or bad business reputation, or criminals, except to the extent that such association is required in the transaction of bail with such persons.

(e) In case the associations defined in (d) above are only with persons related to the licensee or applicant by blood or marriage, on good cause shown the commissioner may issue the license applied for or a restricted license, or may revoke an existing license and issue in lieu thereof a restricted license.

§ 2058. License; Prior Prohibited Associations.

An unrestricted original bail license shall not be issued to any person if within the two-year period immediately prior to his application a license would not have been issued to him for any of the reasons specified in Section 2057 (a); but a restricted bail license may be issued to such person if he presents evidence satisfactory to the commissioner that his bail business will be conducted in a county other than any county wherein he was employed by or associated with a court of law or law enforcement agency; or that such business will be conducted only in a part of the same county so remote from the place of his prior employment that such employment will have no affect on his conduct of his bail business.

§ 2059. Solicitor, Other Licenses Prohibited.

A person licensed as a bail solicitor may not at the same time be licensed as:

(a) A bail agent.

(b) A bail permittee.

(c) A bail solicitor for more than one employer unless all such employers are partners, in which event he shall be licensed as a solicitor for all partners.

TRANSACTION OF BAIL THROUGH PARTNERSHIPS AND EMPLOYEES

§ 2060. Natural Persons Only.

Only natural persons may be issued a bail license.

§ 2061. Transacting as Partners; Notices.

Two or more bail agents or permittees desiring to transact bail as partners shall file with the commissioner the written statement required by Section 2061.2 at least 10 days prior to so transacting, except as provided by Section 2061.3.

§ 2061.1. Partners; Individual Licensing; Rebating.

Each partner shall be licensed individually as a bail agent or permittee, or both, and every partner shall be licensed in the same capacity or capacities as the other members of the partnership so that all partners will be licensed in the same capacity or capacities; except the commissioner may permit the inclusion of an unlicensed partner if evidence is presented satisfactory to him that such unlicensed partner will have no functions, du-

ties or responsibilities involving the actual conduct, supervision or transaction of the bail business.

§ 2061.2. Copartners; Filing Individual Statements.

A written statement subscribed by each partner shall be filed with the commissioner setting forth:

(a) The nature of all businesses conducted or intended to be conducted by the partnership.

(b) The location of the principal place of conduct of the bail business of the partnership and of all other places for the conduct of such business.

(c) The proportion of ownership of each member of the partnership.

(d) An agreement to immediately notify the commissioner of any change in the membership of the partnership or of the matters set forth in (a) to (c) hereof.

§ 2061.3. Change in Partnership; Notices.

Upon any change in the membership of the partnership whether through death, dissolution, addition, deletion, or otherwise, or upon the revocation of the license of any partner, the survivors or successors to the bail business, if they are to act a partnership, shall file a new statement pursuant to Section 2061.2 and shall be subject to the requirements of Section 2061.1. If the change in membership arises through the death or revocation of the license of three or more persons whose partnership agreement provides for continuation of the partnership by the survivors, such survivors may continue to transact bail as a partnership until the expiration of such reasonable period of time as may be specified in any notice which may be sent by the commissioner pursuant to Section 2054.7.

§ 2061.4. Copartnership Suspension; Prohibitions.

If the license of any partner is suspended such partner may not engage in the transaction of bail nor may he receive any commission on, or profit derived from, such transactions entered into by other persons during the period of suspension.

§ 2061.5. Copartnership; Disciplinary Action for Act of One Partner.

The licenses of each member of a partnership are subject to suspension or revocation for the failure of the partnership or of any member of the partnership to comply with all laws and rules governing or regulating the conduct of the bail business or acts incidental thereto if such failure occurred with his express or implied knowledge, consent, ratification or collusion.

§ 2062. Licensed Employees; Notice of Employment.

A bail agent or permittee or a partnership of bail agents or permittees desiring to employ another person licensed as a bail agent or permittee for the purpose of assisting him in his bail business shall file with the commissioner a written statement as required by Section 2062.2 at least 10 days prior to such employment. If prior to the expiration of such 10–day period the commissioner gives notice to the prospective employer specifying wherein such employment would be contrary to any provision of this article or any law relating to bail, such person shall not be employed. If after such 10–day period and after the establishment of the employer–employee relationship the commissioner gives notice to such wherein the continued employer–employee relationship would be contrary to any provision of this article or any law relating to bail, they shall discontinue such relationship within such reasonable time as the commissioner may prescribe.

§ 2062.1. Employee; Licensed in Same Capacity as Employer.

Each such employee (employed pursuant to Section 2062) shall be licensed in the same capacity or capacities as the employing bail licensee or bail licensees.

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§ 2062.2. Employment; Written Notices.

A written statement subscribed by the employer and each such employee (employed pursuant to Section 2062) shall be filed with the commissioner setting forth:

(a) The fact of employment.

(b) The location of the place of business from which the employee will normally transact bail.

(c) The basis of compensation of the employee and if such compensation is to be more than $1,000 per month the amount thereof.

(d) An agreement to immediately notify the commissioner in writing of any change in the matters set forth in (a) to (c) hereof.

§ 2063. Licensed and Unlicensed Employees; Effect.

Sections 2063.1 to 2063.2, inclusive, apply to each employee of a bail agent or permittee whether or not such employee is licensed as a bail agent, permittee or solicitor if such employee performs any duties connected with the transaction of bail by his employer.

§ 2063.1. Employer Supervision; Disciplinary Action.

An employing bail agent or permittee shall exercise a reasonable degree of supervision over his employees and make a reasonable effort to keep informed of their acts as his employees. Failure of the employer to exercise such supervision resulting in the violation of law or these regulations by the employee may result in disciplinary action against the employer.

§ 2063.2. Branch Offices.

A bail licensee (i.e., the owner, a partner or a licensed employee) shall be in charge, as his usual and customary place of business, of each branch office.

§ 2063.3. Solicitor; Transactions and Conduct.

A bail solicitor shall not conduct a bail business or transact bail under any name or at any address other than that of his employer, nor shall he use any forms or documents in connection with a bail transaction other than those of his employer.

CONDUCT OF BAIL LICENSEES

§ 2064. Bail Licensees; Capacity and Conduct.

Every bail licensee shall conduct his business in such a manner that the public and those dealing with him shall be aware of the capacity in which he is acting, and if he transacts bail both as an employee and as an individual or in any other dual capacity, each such transaction shall be so conducted that the public and those dealing with him shall not be confused as to the capacity in which he acts.

§ 2065. Business in Specified Capacities Only and Notices.

Every bail agent or permittee shall conduct his bail business:

(a) As an individual;

(b) As a member of a partnership as provided in Section 2061;

(c) As an employee of another bail agent or permittee as provided in Section 2062;

(d) As the temporary associate of another bail agent or permittee in the joint transaction of bail if such temporary association is limited to a single transaction or to a series of related transactions;

(e) As the temporary conductor of the bail business of another bail a period of his temporary absence; or

(f) In any other lawful manner provided written notice is filed with the commissioner by the bail licensee at least 10 days prior to his so conducting his bail business setting forth full details of the manner in which the business will be conducted and the names of all persons, if any, to associated with him. If prior to the expiration of such 10-day period the commissioner gives notice to such bail licensee specifying wherein the intended conduct of the business would be contrary to any provision of this article or any law relating to bail, such bail licensee shall not so conduct his business. If after such 10-day period the commissioner gives notice to such bail licensee specifying wherein the continued conduct of his bail business would be contrary to any provision of this article or any law relating to bail, he shall discontinue to so conduct his business within such reasonable time as the commissioner may prescribe.

§ 2066. Business in Own Name.

Except as provided in Section 1724.5 of the Insurance Code and the commissioner's regulations promulgated thereunder (Sections 2050 and following of Title 10 of the California Administrative Code) and Sections 2066.2, 2066.3, 2066.4 hereof, every bail licensee shall do business in his own name.

§ 2066.1. Using Employer's Name.

Every bail agent and permittee employed by another bail agent or permittee pursuant to Section 2062 and acting as such and every bail solicitor shall do business only in the natural name or fictitious name, if any, of his employer.

§ 2066.2. Using Predecessor's Name.

The permission under Section 1724.5 of the Insurance Code to use a predecessor's name in case a bail agent or permittee purchases or succeeds to the bail business of another bail agent or permittee is applicable only where the business so purchased or succeeded to was a bona fide business which the predecessor or predecessors had actively conducted as a bail business for at least 5 consecutive years.

§ 2066.3. Fictitious Names; Filing, Similar Names.

Prior to its use, a fictitious name or style must be:

(a) Filed with and approved by the commissioner in writing.

(b) Filed with the county clerk of all counties in which user thereof maintains an office for the transaction of bail or in which he contemplates the active solicitation of bail under such fictitious name or style.

(c) Worded in compliance with the requirements of Section 1724.5 of the Insurance Code and the regulations of the commissioner promulgated under authority thereof (Sections 2050 and following of Title 10 of the California Administrative Code).

§ 2066.4. Disapproval of Fictitious Name.

If the commissioner gives notice to a bail agent or permittee specifying wherein the continued use of a fictitious name would be in violation of any of the provisions of the Insurance Code or this Article, such bail agent or permittee shall discontinue the use of such fictitious name subject to such extension of time as the commissioner may prescribe pursuant to the provisions of Section 1724.5 of the Insurance Code.

§ 2066.5. Advertising of Fictitious Names.

All advertising or telephone listings in the yellow pages of telephone directories shall contain the true name of the licensee(s) who owns it with equal prominence with that of the fictitious name, so that there will be no indication that another separate business exists when in fact, the ownership is the same.

§ 2067. Misrepresenting Capacity, Authority.

No bail licensee shall directly or indirectly represent that he is a fidelity or surety insurer or that he has the authority or powers of a bail permittee, bail agent or bail solicitor unless he is licensed as such nor shall he misrepresent his authority or power to act on behalf of a surety insurer; nor shall he advertise his bail business in the yellow pages of the telephone directory under "Surety" or "Fidelity."

§ 2068. Transactions by Unlicensed Persons; Prohibitions.

No bail licensee shall directly or indirectly permit any person on his behalf to solicit or negotiate undertakings of bail or bail bonds or to effect undertakings of bail or to issue or deliver bail bonds unless such person is properly licensed by the commissioner to perform such acts, even though such person acts in a purely mechanical or ministerial manner or renders his services gratuitously. This section shall not prevent a bail agent or permittee from suing the mail, or any messenger or delivery generally, to file executed undertakings of bail or deliver bail bonds, nor shall it prevent such filing or such delivery by the attorney or other agent of the

arrestee. No person in the employment of the licensee shall act as an agent of the arrestee in the performance of any of the acts specified herein.

§ 2069. Confidential Communications; Information.

No bail licensee shall disclose or reveal any information coming into his possession or to his knowledge concerning an impending arrest or detention of a person by a law enforcing agency, except in accordance with the lawful inquiry of a law enforcement or judicial officer, unless such information is a matter of public record or knowledge.

§ 2070. Agreements for Bail Before Arrest; Prohibited.

No bail licensee shall enter into an agreement or arrangement with any person, which agreement or arrangement has for its purpose the guaranteeing or assuring such person or any other person in advance of the commission of any offense that bail will be furnished to such person or any other person when and if such person or any other person is arrested, nor shall any bail licensee perform any act which will encourage any person to violate the law.

§ 2071. Suggesting or Recommending Attorney; Prohibited.

No bail licensee shall in any manner, directly or indirectly, suggest the name of or recommend any attorney to any arrestee or person purporting to act for or represent an arrestee.

§ 2072. Acting for Attorney; Prohibited.

No bail licensee shall receive, accept or collect for, or transmit to, any attorney any money or other item of value for attorney's fee, costs or any other purpose on behalf of an arrestee or any other person with whom bail is negotiated. Any bail licensee who is lawfully holding any money or other item of value as collateral may, however, upon the release of such collateral, honor an assignment thereof to an attorney if the licensee took no part in the negotiation of such assignment. No bail licensee shall furnish forms for or otherwise aid in such assignment.

§ 2073. Preparation of Writ of Habeas Corpus; Prohibited.

No bail licensee or his employees shall prepare, make, or assist in any manner in the preparing, making or filing of a petition for a writ of habeas corpus for or on behalf of an arrestee. Such licensee or his employees may, however, without charge and in accordance with the specific directions of the attorney of the arrestee, perform such mechanical ministerial acts as will assist such attorney in preparing or making such petition.

§ 2074. Unlawful Solicitations; Place.

Except as provided in Sections 2074 and 2079.5, no bail licensee shall solicit any person for bail in any prison, jail, or other place of detention of persons, court or public institution connected with the administration of justice; or in the halls or corridors adjacent thereto; provided that a bail licensee may in such halls, corridors or in other rooms or areas where not prohibited by local rule or ordinance transact bail with persons specified in Section 2079 who have prior to transaction, requested his services.

§ 2075. Regulations of Public Authority; Compliance.

Every bail licensee shall fully comply with every rule, regulation or ordinance issued by a proper public authority governing the conduct of persons in or about any prison, jail or other place of detention of persons, court or public institution connected with the administration of justice. This section shall not be construed to authorize any act constituting a violation of any other section of this article which is done pursuant to any rule, regulation or ordinance that is merely permissive in its nature.

§ 2076. Informing or Notifying of Arrests; Prohibitions.

No bail licensee shall, for any purpose, directly or indirectly, enter into an arrangement of any kind or have any understanding with a law enforcement officer, newspaper employee, messenger service or any of its employees, a trusty in a jail, any other person incarcerated in a jail, or with any other persons, to inform or notify any licensee (except in direct answer to a question relating to the public records concerning a specific person named by the licensees in the request for information), directly or indirectly, of:

(a) The existence of a criminal complaint;

(b) The fact of an arrest; or

(c) The fact that an arrest of any person is impending or contemplated.

(d) Any information pertaining to the matters set forth in (a) to (c) hereof or the persons involved therein.

§ 2077. Fictitious Communications.

No bail licensee shall, directly or indirectly, transmit or cause to be transmitted to himself or to any other person a communication authorizing said licensee or any other person to solicit or negotiate bail which is a fictitious communication or which is from a person other than a person from whom he may lawfully solicit bail pursuant to Section 2079 or with whom he may lawfully negotiate bail pursuant to Section 2080. No such communication shall, at any time or in any manner, be used directly or indirectly as an aid in securing information concerning a person confined in a jail, prison or other place of detention or for the purpose of visiting an arrestee therein, or for any other purpose.

§ 2077.1. Identification Card.

Every bail licensee shall keep in his possession an identification card issued to him by the commissioner and shall, upon request, show it to any person with whom he transacts bail. He shall not permit any person other than himself to use his identification card for any purpose. The identification card shall be returned to the commissioner immediately upon the termination of all of the holder's bail licenses.

§ 2078. Gifts Prohibited.

No bail licensee shall give, directly or indirectly, any gift of any kind to any public official or employee of any governmental agency who has duties, functions or responsibilities in respect to the administration of justice or a place wherein detention of persons charged with crime may occur, or to a prisoner any jail or place of detention. Items of nominal value which are distributed generally for the purpose of advertising shall not be considered gifts for the purpose of this article, except if given to prisoners or persons directly in charge of prisoners in their place of detention; nor shall this article prevent the customary giving of gifts to relatives by blood or marriage. But nothing in this Section shall be construed to justify any rebate or bribe.

§ 2079. Soliciting of Bail; Persons.

No bail licensee shall solicit bail except in accordance with Section 2079.5 and from:

(a) An arrestee;

(b) The arrestee's attorney;

(c) An adult member of the arrestee's immediate family; or

(d) Such other person as the arrestee shall specifically designate in writing. Such designation shall be signed by the arrestee before the solicitation, unless prohibited by the rules, regulations or ordinances governing the place of imprisonment. If so prohibited, it may be signed after release of the arrested to ratify a previous oral designation made by him.

§ 2079.1. Solicitation of Arrestee; Hours.

Any solicitation of an arrestee himself pursuant to Section 2079 (a) shall be only after a bona fide request for bail services has been received from the arrestee or from a person specified in Section 2079 (b) or (c). Any solicitation of a person specified in Section 2079 (c) or (d) shall be only between the hours of 7 o'clock a.m., and 11 o'clock p.m., unless the bail licensee is directly and specifically authorized in writing by the arrestee or the arrestee's attorney to make such solicitation at some other specific time.

§ 2080. Negotiation of Bail; Persons.

No bail licensee shall negotiate concerning bail, except with:

(a) A person specified in Section 2079;

(b) Any other person who without previous solicitation on the part of the bail licensee has requested his services.

§ 2081. Collection and Charges Permitted.

No bail licensee shall, in any bail transaction or in connection therewith, directly or indirectly, charge or collect money or other valuable consideration from any person except for the following purposes:

(a) To pay the premium at the rates established by the insurer and set forth on the undertaking of bail or to pay the charges for the bail bond filed in connection with such transaction at the rates filed in accordance with Section 2094.

(b) To provide collateral.

(c) To reimburse himself for actual, necessary and reasonable expenses incurred in connection with the individual bail transaction, including but not limited to:

(1) Guard fees after the first 12 hours following release of an arrestee on bail;

(2) Notary fees, recording fees, necessary long distance telephone expenses (i.e., telephone calls billed by the telephone company as "long distance," but not those for which "message unit" charges only are made); telegram charges, travel expenses and verification of collateral outside of the county where the bail was arranged; a reasonable posting fee charged by a licensee operating in a county other than that where the bail was arranged; providing that no charge shall be made for travel from the licensee's office to post bail in an area where the licensee advertises in the yellow pages of the telephone directory unless the advertisement specifically so states. Such travel charges, when permitted, shall not exceed the amount allowed to be taken as a travel expense for income tax purposes under the federal Internal Revenue Code and Regulations thereunder, or the amount allowed by the State of California to be claimed for mileage by its employees, whichever the licensee chooses.

(d) To reimburse himself for actual reasonable and necessary expenses incurred and caused by a breach by the arrestee of any of the terms of the written agreement under which and pursuant to which the undertaking of bail or the bail bond was written. Such reimbursement may not exceed the penal amount of such undertaking or bond and may include a reasonable charge for the services of the licensee, his employees, partners or other persons associated with him in the particular transaction of bail.

(e) If a forfeiture of bail occurs and is not set aside, the expenses under (c) and (d) of this Section which are incurred within 180 days of such forfeiture may be charged in addition to the amount of such forfeiture.

§ 2082. Prohibited Service Charges.

Except to the extent permitted by Section 2081 (c), (d), and (e), no bail licensee shall make any charge for his services in a bail transaction in addition to the premium on an undertaking of bail or the charge for a bail bond at the rates filed in accordance with Section 2094.

§ 2083. Written Statements of Bail Transactions; Contents; Delivery.

Every bail licensee shall, at the time of obtaining the release of an arrestee on bail or immediately thereafter, deliver to such arrestee or, if the negotiations concerning the bail were not with the arrestee, to the principal person with whom such negotiations were had, a numbered document containing the following information:

(a) If an undertaking of bail, the name of the surety insurer.

(b) The name and address of the bail licensee.

(c) The name of the arrestee.

(d) The date of release of the arrestee.

(e) The date, time and place of the arrestee's required appearance.

(f) The amount of bail.

(g) The offenses with which the arrestee is charged.

(h) The premium if an undertaking of bail, or the charge if a bail bond.

(i) An itemization of all actual expenses described in Section 2081 (c) and (d), supported by vouchers and receipts, or true copies thereof.

(j) The total amount of all charges.

(k) The amount received on account.

(l) The unpaid balance, if any.

(m) A description of and receipt for any collateral received and a statement of any conditions relating thereto including a copy of any written agreement executed in connection therewith.

§ 2083.1. Same; Additional Statements.

If, after the release of an arrestee, additional expenses are incurred or charges made, the bail licensee shall immediately deliver to the person specified in Section 2083 an additional numbered document containing the information, required by Section 2083 (h), (i), (j), (k) and (l).

§ 2084. Guarantor Agreements; Delivery; Notices.

All guarantor agreements shall be in writing, or reduced to writing as soon as possible after consummation. If any person acts as a guarantor, a copy of the guarantor's agreement shall be delivered to him promptly upon his execution thereof. No bail licensee shall enforce any such agreement without disclosing to the guarantor all collateral held by such licensee indemnifying the bond to which the agreement relates, and the identity of all other guarantors thereof, if any.

§ 2086. Undertakings of Bail; Delivery; Compliance.

No bail licensee shall deliver an undertaking of bail which does not comply with all of the provisions of Section 381 of the Insurance Code.

§ 2087. Waiver of Rights of Guarantor, Prohibited.

No bail licensee shall require the waiver by a depositor of collateral or by a guarantor of any right he might have or thereafter acquire in connection with any bail transaction. No bail licensee shall require or accept in connection with any bail transaction any waiver of defense, confession of judgment, or other agreement impairing the right of the person with whom the bail is negotiated or any depositor of collateral or guarantor to a determination of his rights in a civil court.

§ 2088. Collateral; Fiduciary Relation.

Any bail licensee who receives collateral in connection with a bail transaction shall receive such collateral in a fiduciary capacity, and prior to any forfeiture of bail shall keep it separate and apart from any other funds or assets of such licensee.

§ 2088.1. Collateral; Custody Thereof.

If pursuant to his agreement or contract of agency employment or partnership any bail licensee is or may be required, or in fact does, transfer collateral to another bail licensee, general agent, or surety insurer, such recipient of said collateral shall hold it in the same fiduciary capacity as the bail licensee, return it, and otherwise handle it in conformity with Sections 2088 through 2089, both inclusive, hereof. Such collateral shall only be transferred to another bail licensee or to a surety insurer holding a certificate of authority in California and said collateral shall not be removed from this state.

§ 2088.2. Return of Collateral.

Any collateral received shall be returned to the person who deposited it with the bail licensee or to any assignee of such person, other than the bail licensee or his representative, as soon as he is advised that the obligation, the satisfaction of which was secured by the collateral, is discharged. It is the duty of the bail licensee or surety insurer to determine promptly whether such obligation has been discharged upon request for return of the collateral by the person depositing it or by his assignee. If the collateral was deposited to secure the obligation of a bond, it shall be returned immediately upon the entry of any order by an authorized official by virtue of which liability under the bond is terminated. If any licensee or surety insurer which has custody of the collateral fails to take promptly any action necessary to secure the termination of such liability, he shall return such collateral immediately upon the accrual of any right to secure an order of termination of liability. If such collateral was deposited as security for unpaid premium or charges and if such premium or charges remained unpaid at the time of exoneration and after demand therefor has thereafter been made by the licensee or surety insurer which has custody of the collateral, the collateral other than cash may be levied upon in the manner provided by law and the proceeds of such collateral may be applied to the amount of such unpaid premium or charges.

§ 2088.3. Real Property as Collateral.

If a bail licensee receives as collateral in a bail transaction, whether in his own or on another's behalf, any document which conveys title to real property, such document shall state on its face that it is executed as part of a security transaction. If such document is recorded, a reconveyance of such property executed in such a manner that it may be recorded shall be delivered by the responsible bail licensee or surety insurer to the person executing the original conveyance or to his heirs, legal representative or successor in interest immediately upon such responsible party learning of the satisfaction of the obligation secured; and it is the duty of such responsible party to determine promptly whether such obligation has been discharged upon request for return of the collateral by the person entitled thereto.

§ 2089. Return of Excess Collateral on Forfeiture.

If collateral received is in excess of the bail forfeited, such excess shall be returned to the depositor immediately upon the application of the collateral to the forfeiture; subject, however, to any claim for unpaid premium or charges as provided in Section 2081.

§ 2090. Surrender of Arrestee to Custody; Return of Premiums.

No bail licensee shall surrender an arrestee to custody prior to the time specified in the undertaking of bail or the bail bond for the appearance of the arrestee, or prior to any other occasion when the presence of the arrestee in court is lawfully required, without returning all premium paid for such undertaking or bond; except that when as the result of judicial action, information concealed or misrepresented by the arrestee or other reasonable cause, any one of which was material to the hazard assumed, and the licensee can show that the hazard was substantially increased, then the bail licensee may retain incurred out of pocket expenses permitted to be charged by Section 2081 (c) and (d). The surrender of an arrestee who is again in custody for an offense for which a penalty greater than that for the original offense may not be imposed, or his surrender at the request of the guarantor shall never, in and of themselves, be considered to be reasonable cause for surrender, and in case of any surrender under such circumstances, and no actual and substantial increase in hazard can be shown by the licensee, all premiums received and incurred expenses shall be returned. Compliance with an Order of the Court made pursuant to Section 1300(b) of the Penal Code shall be in compliance with this Section; and a licensee at the time of any surrender of an arrestee prior to the time specified in the undertaking of bail shall inform such arrestee of his rights under said Section 1300(b) to petition the Court for a ruling as to return of premium.

§ 2091. Forfeitures; Misrepresentations.

No bail licensee shall make any misleading or untrue representation to a court or to a public official for the purpose of avoiding or preventing a forfeiture of bail or of having set aside a forfeiture which has occurred, or for the release of an arrestee on his own recognizance after bail has once been placed by the licensee. A copy of all written representations made by or on behalf of a bail licensee for such purpose shall be kept as provided in Section 2098, unless such representations are filed by an official as a public record.

§ 2092. Interrogations; Licensee Must Answer.

Every bail licensee must truthfully answer any question asked him by the commissioner or his representative about his bail transactions or matters relating to the conduct of his bail business, subject only to his lawful constitutional rights against self-incrimination.

FILINGS AND RECORDS

§ 2094. Filing Schedule of Charges.

Every bail permittee shall file with the commissioner a schedule of charges to be made for bail. He shall also file with the commissioner any change in such charges at least five days prior to the effective date thereof. Such charges and changes so filed are public records.

§ 2094.1. Rates Chargeable.

No bail permittee shall issue or deliver a bail bond except at the rates most recently filed with the commissioner in accordance with Section 2094.

§ 2094.2. Filing of Charges; Differences in Rates.

If a person is licensed as both a bail agent and a bail permittee or licensed in either capacity but conducting his bail business under an agreement with a person licensed in the other capacity, any filing made pursuant to Section 2094 shall state all differences between the premiums charged for undertakings of bail and the charges made for bail bonds and the reasons therefor. If there is any such difference and if for his own convenience a bail licensee shall substitute or cause to be substituted one type of obligation for the other, he shall do so without additional premium or charge. Such substitution without additional premium or charge may not be used as a device or means of avoiding compliance with Section 2094 or with Chapter 9, Part 2, Division 1 of the Insurance Code.

§ 2095. Filings; Necessary Notices.

Every bail licensee shall promptly file with the commissioner the following:

(a) If conducting business as a partnership pursuant to Section 2061, the written statement required by Section 2061.2 and any modification thereof.

(b) If the relationship of a bail agent or permittee employed by another bail agent or permittee or a partnership of bail agents or permittees exists as set forth in Section 2062:

(1) The written statement to the commissioner required by Section 2062.2;

(2) The written notice of any change as required by Section 2062.2 (d).

(c) The written notice required by Section 2065 (f) if applicable to such licensee.

(d) The written notice required by Section 2066.4 (a) of any fictitious name or style used pursuant to Section 2066.4.

(e) A written notice of any changes made in any of the licensee's business addresses.

(f) A complete list of all persons employed by the licensee who aid him in any way in the conduct of his bail business setting forth for each employee the full name, duties and basis of compensation, and if such compensation is to be over $1,000 per month the amount thereof.

(g) A notice containing the same information as that required by (f) above for each new employee.

(h) A notice of termination of the employment of any employee and, if the reason therefor was any act or conduct by the employee which would in the opinion of the employer indicate an unfitness to transact bail, a full statement of such reason.

(i) A notice within 10 days after service upon him of the filing of:

(1) Any criminal suit;

(2) Any action at law against him or of any judgment against him which arises out of his transaction of the bail business or the transaction of bail.

(j) A written notice within five days after making any arrangement of any kind to obtain money, securities or other assets to use directly or indirectly in the bail business, giving the name of the person with whom such arrangements have been made, the amount of money or value of other assets involved, the date of the transaction and the details of the arrangement.

(k) A copy, or a reference to copies already filed and which he will use, of all forms or documents which the licensee intends to use regularly or frequently in connection with his bail transactions, including:

(1) The document to be delivered to the arrestee or other person containing the information required by Section 2083;

(2) The form of any receipt for or agreement relating to collateral used pursuant to Section 2083 (m);

(3) The document to be delivered to the arrestee or other person containing the information required by Section 2083.5;

(4) The form of guarantor's agreement referred to in Section 2084;

(5) The form of original communication referred to in Section 2097 (a);

(6) The form or original application referred to in Section 2097 (b); and

(7) Any other form or document.

§ 2096. Improper Forms; Notice.

If the commissioner finds that any form or document, the filing of which is required by Section 2095 (k), is misleading or contrary to any provision of this article or any law relating to bail, he shall notify the bail licensee specifying wherein such form or document is misleading or contrary to any provision of this article or any law relating to bail. Thereafter such bail licensee may not use such form or document. If such notification is not given to such licensee within 30 days after the filing of such form or document, the commissioner shall prescribe a reasonable time after which such form or document may not be used.

§ 2097. Documents; Retention of Originals or Duplicates by Licensee.

Every bail licensee shall retain in his records the original or duplicate original of the following:

(a) Any written request received by him from an arrestee or person acting on his behalf which resulted in the posting of bail by such licensee.

(b) The application for bail signed by the arrestee or person negotiating bail on his behalf.

§ 2098. Documents; Retention of Copies by Licensee.

If a bail licensee has arranged for the posting of bail, he shall in each case retain in his records a copy of the following documents:

(a) The document or documents furnishing the arrestee or person negotiating bail on his behalf with the information required by Section 2083.

(b) The collateral receipt or any form of agreement relating thereto described in Section 2083 (m).

(c) The document listing additional charges required by Section 2083.5.

(d) Any written representation made to a court or a public official with respect to the matters dealt with in Section 2091.

(e) An guarantor's agreement.

(f) All documents signed by the arrestee or any person with whom bail is negotiated, the originals of which are not retained by the licensee.

(g) All documents delivered to the arrestee or any person with whom bail is negotiated.

§ 2099. Documents; Tender to Arrestee or Representative.

Every bail licensee shall tender a copy of any document which is executed by any person with whom bail is negotiated to such person at the time of the execution thereof.

§ 2100. Necessary Record; Open to Inspection.

Every bail agent or permittee shall keep complete records of all business done under authority of his license or under the authority of the license of any bail solicitor, bail agent or bail permittee employed by him. All records kept by such agent or permittee, including all documents and copies thereof shall be open to inspection or examination by the commissioner or his representatives at all reasonable times, at the principal place of business of the licensee as designated in his license. Such records shall include at least the following information as to each bail transaction shown either in one of the forms required by the provisions of these rules or in a separate book, ledger, or card record:

(a) The full name and address of the arrestee.

(b) The date of arrest, the offense with which the arrestee was charged, the penal amount of the bail, the premium for the undertaking of bail or the amount charged for the bail bond, the date the bail was filed or delivered, and the court or public official before whom the arrestee must appear.

(c) The full name and address of the person furnishing information leading to the solicitation or negotiation of the bail, the date and time such information was received, the manner in which it was received, the connection or relationship to the arrestee of the person other than the arrestee furnishing such information, and the name of the person receiving such information.

(d) If the bail was negotiated with any person other than the arrestee, the full name, address and connection or relationship to the arrestee of such person, and the name of the person who carried out the negotiations on behalf of the licensee.

(e) If the bail was negotiated directly with the arrestee, a full statement of the manner in which the arrestee communicated with the licensee and the name of the person receiving such communication.

(f) The full name and address of each and every person directly or indirectly paying, promising to pay, or guaranteeing the payment of, the whole or any part of the premium, guard fees, charges for extraordinary services, or collateral made or deposited in connection with a bail transaction.

(g) The name of any bail licensee from whom the business was accepted or to whom commission was promised or paid in connection therewith, and the amount of commission promised or paid.

(h) The name of any person who received or was promised any portion of a premium, guard fee, charge or commission or was compensated in any manner directly or indirectly on account of any bail transaction.

(i) If any valuable consideration other than money was received in connection with a bail transaction, a full statement in explanation of such consideration and the circumstances attendant thereto.

(j) Where a writ bond was issued, the name of the attorney appearing thereon.

(k) A separate book record which shall show the date of receipt of any collateral as a guarantee in a bail transaction, the name of the person from whom it was received, the name of the person receiving it, a complete description of the collateral, the amount of bail guaranteed, the amount of premium guaranteed and the disposition of the collateral. If the collateral was returned, the date of its return and the name of the person to whom it was returned.

§ 2101. Copartnership Records; Filings.

During the period when two or more bail licensees are conducting their business as a partnership pursuant to Section 2061, such licensees may combine their books and records and make a joint filing with the commissioner of all forms used by them as a partnership, provided, however, that such books and records shall identify the member of the partnership who actually transacted each individual bail transaction or portion thereof.

§ 2101.1. Records; Licensed Employees.

Every employing bail agent or permittee shall keep at his office all books and records concerning the bail transactions of himself and his employees while acting as such, and such employees may use all forms filed, directly or by reference, with the commissioner by such employer; provided, however, that such books and records shall identify the particular person who actually transacted each individual bail transaction or portion thereof. But the employed bail agent or permittee is responsible for the maintenance of such records, and the proper use of such forms for the transactions in which he participates.

§ 2101.2. Records; Temporary Associations.

If two or more bail agents or permittees are temporarily associated for the purposes of a single or series of bail transactions, each shall be responsible for keeping sufficient records to identify the transactions and to meet the requirements of this article with respect to the portion of the transaction conducted by him.

§ 2101.3. Records; Temporarily Conducting Business.

During the time a bail agent or permittee is temporarily conducting the business of another bail agent or permittee as provided in Section 2065 (e), such bail agent or permittee shall be responsible for the proper entries in and the retention of the books and records of such other bail agent or permittee but he may use the forms and documents usually used by the permanent owner of the bail business. Following such temporary conduct

of his business the permanent owner of such business is responsible for the retention of such books and records.

§ 2102. Use of Filed Documents and Forms.

Except as provided in Sections 2101.1 to 2101.3, inclusive, every bail agent and permittee shall use the forms and documents filed, directly or by reference, by him with the commissioner as an individual and shall be individually responsible for the proper entries in and the retention of all books and records.

§ 2103. Information; Not Required; Severability.

Any bail licensee secure from any person with whom he engaged in a bail transaction information in addition to that required by these rules or his signature to documents other than those required by these rules. If such information is secured as a part of the same document which contains any of the information required by these rules, it shall be clearly severable and the licensee, in using such document, may, at his discretion, omit the use of the portion of it which is not required by these rules.

§ 2104. Destruction of Records.

Five years after the final completion of all parts of a bail transaction, a bail licensee may destroy his records pertaining to such transactions.

Article 2.1. Bail Education

§ 2105.1 Definitions.

(a) "Class" means a presentation of course material to a specific group of enrolled students.

(b) "Classroom" means a prelicensing or continuing education place of instruction with sufficient space designed so that instructor(s) and students can communicate face–to–face in a physical facility with a high degree of privacy and relative freedom from outside interferences. Computer instruction is not considered a classroom per Section 1810.7 of the California Insurance Code (CIC).

(c) "Commissioner" means the California Insurance Commissioner.

(d) "Course" means education taken or given to satisfy the requirements of Insurance Code section 1810.7(a).

(e) "Department" means the California Department of Insurance.

(f) Electronic Filing" means the submission of provider rosters and class presentation schedules to the Department by a provider using the Department website, electronic flat file, diskette, compact disc (CD), or digital versatile disc (DVD), or other electronic technology compatible with Department technology.

(g) "Electronic Signature" means a CDI assigned provider log–in/–out number that allows providers to submit class presentation schedules and provider rosters online or by other electronic means. For the purpose of section 2105.7(c), "Electronic Signature" means a provider assigned student log–in/–out number that allows providers to monitor student activity.

(h) "Fee Schedule" means the bulletin issued pursuant to Insurance Code section 12978 entitled State of California, Department of Insurance, Schedule of Fees and Charges.

(i) "Instructor" means a person who teaches a course to students on behalf of an approved provider.

(j) "Original signature" means the provider director's actual signature. Original signatures are required on the Prelicensing/Continuing Education Program, Provider Certification/Renewal Application, Form 446–2, and the Bail Course Approval/Renewal Application, Form LIC001B, when these forms are submitted in a paper format rather than on–line. A provider may utilize either a controlled signature stamp, a computer generated signature, or appoint an authorized designee for purposes of signing any other forms. Prior to using either a signature stamp or a computer generated signature, the provider must submit to the Department a letter thoroughly explaining the steps that the provider has taken to ensure the security of either the stamp or computer generated signature. Prior to utilizing an authorized designee, the provider must submit to the Department a list of the names of the persons so authorized, along with a sample of each person's signature or computer generated signature.

(k) "Provider" means an individual or business entity who offers prelicensing or continuing bail education courses to students or prospective students.

(*l*) "Provider director" means the individual employed by a provider who the provider has designated as the person responsible for administering the provider's prelicensing and continuing education business.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New article 2.1 (sections 2105.1–2105.19) and section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.2. Prelicensing Education Curriculum.

An approved prelicensing bail education course must be taught in a classroom and must impart information on all of the following topics. Each topic below must be cross referenced to the material submitted to the commissioner before the material can be approved:

(a) Insurance Code sections 1724.5, 1733, 1734, 1735; Article 6 commencing with section 1666; Article 13 commencing with section 1737; sections 1800 – 1823;

(b) California Code of Regulations, Title 10, Chapter 5, Subchapter 1, Article 2, sections 2053 – 2104;

(c) Penal Code sections 1166, 1195, 1269b, 1269c, 1270, 1270.1, 1275, 1276.5, 1285, 1286, 1296, 1298, 1299, 1301, 1302, 1304, 1306;

(d) 18 United States Code 1033 and 1034;

(e) Common law and ethical duties of bail agents to sureties, arrestees, indemnitors and others;

(f) Overview of bail and the function of bail agents;

(g) Criminal and courtroom procedures;

(h) Special obligations to the court;

(i) Collateralizing bail undertakings;

(j) Fugitive location methods and resources; and,

(k) Interaction with police and prosecutors.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.3. Providers.

(a) Provider Approval

(1) An individual or business entity who wants to be approved as a provider must submit to the Department a Prelicensing/Continuing Education Program Provider Certification/Renewal Application, which appears as section 2105.12, along with the fee recited for Insurance Code section 1751.1(a) as listed in the Fee Schedule.

(2) A provider shall not be approved if an incomplete application is submitted to the Department. The incomplete application will remain on file for one year unless withdrawn by the applicant. After one year, a new application is required. Notification that an application is complete does not mean approval has been or will be granted. The Department must decide whether to approve a provider within sixty (60) days of receiving a completed application. If the Department initiates an investigation of an applicant for an alleged violation that would, if proven, result in the suspension, revocation, or denial of the provider's approval to provide prelicensing or continuing education to bail agents, the sixty (60) day period will toll until the completion of the investigation. If, after completion of the investigation, the applicant is referred to the Department's Legal Division, the Department will have thirty (30) days from the date of the referral to issue a Statement of Issues pursuant to Government Code section 11504, or to issue the approval.

(3) The Department may refuse to approve a provider based on any of the grounds for which it may deny an insurance agent license under Insurance Code sections 1668 or 1668.5.

(4) A nonresident applicant for provider approval must file with the Department a Prelicensing/Continuing Education Program Out–of–State Provider Jurisdiction Agreement, which appears as section 2105.13.

(5) The Department may investigate and require the filing of any supplementary documents, affidavits and statements it deems necessary to obtain information that will aid in determining whether the prerequisites for approval have been met.

(6) Provider approval will be valid for two (2) years from the date it is granted.

(b) Renewal of Provider Approval

(1) To renew approval, a provider must submit to the Department a Prelicensing/Continuing Education Program Provider Certification/Renewal Application along with the fee recited for Insurance Code section 1751.1(b) listed in the Fee Schedule.

(2) Approval as a provider may not be renewed if the renewal application is incomplete. The Department must inform all renewal applicants in writing if the application contains deficiencies requiring correction, and the nature of those deficiencies.

(3) Renewal applications must be received by the Department at least sixty (60) days before the provider's approval expires to maintain continuity of approval.

(4) An incomplete renewal application will remain active for one year unless withdrawn by the applicant. After one year, a provider must submit a new application. Notification that an application is complete does not mean approval or disapproval. The Department must decide whether to renew the approval within sixty (60) days of receiving a completed application.

(5) A provider whose approval has expired may late renew up to sixty (60) days after the expiration date. If a renewal is received by the Department more than sixty (60) days after expiration of approval, the provider must re-file the Prelicensing/Continuing Education Program Provider Certification/Renewal Application for approval.

(6) A provider whose approval has expired may not present a class for credit until the Department has issued a written notice of renewal.

(c) A provider must notify the Department in writing within ten (10) days following any change in information recorded on the Prelicensing/Continuing Education Program Provider Certification/Renewal Application.

(d) A provider must obtain the Department's written consent before using a fictitious name in an act for which provider approval is required. A provider must notify the Department if it changes or discontinues use of a true or fictitious name. The Department may in writing disapprove the use of a fictitious or true name, other than the legal name of an individual, on any of the following grounds:

(1) The name interferes with or is too similar to a name already filed with the Department and in use by another approved provider;

(2) the use of the name might mislead the public in any respect; or

(3) the provider or applicant has already obtained approval for the use of a fictitious name and has not agreed to discontinue the use of that name. This subdivision does not prevent a provider or applicant who has lawfully purchased or succeeded to the business or businesses of other providers from using for each such business not more than two additional names, true or fictitious, consisting of names used by the predecessor businesses in their conduct as approved providers.

(e) Providers shall offer courses to all students at the same per course fee.

(1) By the last day of each month, a provider shall establish a course fee schedule to be in effect for all students who, in the following month, purchase a course or set of courses.

(2) The course fee schedule shall state the month and year in which it will be in effect, and be dated and signed by the provider director on the date on which the provider commits to using the schedule.

(3) The course fee schedule must include a price for each course or set of courses that will be available for purchase in the month for which the schedule applies.

(4) A course fee schedule may not have the effect of discriminating in the amount of course fees based solely on membership or lack of membership in any group or association, including employment by any employer.

(5) No person may purchase from a provider the right to enroll a student in a course and sell that right to a student for more or less that the person paid the provider. No person may sell to a student the right to enroll in a course, or enroll a student in a course, and charge that student more or less than the person paid or will pay for the course.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8-20-2007; operative 9-19-2007 (Register 2007, No. 34).

§ 2105.4. Instructor Qualifications.

(a) An approved provider must ensure that each approved course is taught by an instructor who has at least three (3) years of experience within the last five (5) years in the subject matter of the course. The instructor must complete a Prelicensing/Continuing Education Program Instructor Qualification Form, which appears as section 2105.14, which must then be signed by the provider director.

(b) The Department may direct a provider not to use an instructor who does not meet the instructor qualifications recited in this section or does not adhere to other applicable requirements stated in these regulations.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7(c), Insurance Code.

HISTORY

1. New section filed 8-20-2007; operative 9-19-2007 (Register 2007, No. 34).

§ 2105.5. Course Approval.

(a) To obtain approval of a course, a provider must submit to the Department a Bail Course Approval/Renewal Application, which appears as section 2105.15, along with the fee recited for Insurance Code sections 1751.1(c) and (e) listed in the Fee Schedule.

(b) A course approval application must be received by the Department at least thirty (30) days before the date the course will be presented to students for the first time. An incomplete course approval application will remain active for one year from the date of receipt, unless withdrawn by the provider. After one year, a provider must submit a new application. Notification that an application is complete does not mean approval or disapproval. The Department must approve or reject a course within thirty (30) days of receiving a completed application.

(c) A provider of a classroom course must notify the Department of the classroom location(s) where the provider intends to present the course, including the street address, city, state and zip code, and the dates and times of the presentation. The notification must be submitted to the Department using electronic filing at least ten (10) business days before each time a class in which the course will be presented is scheduled to meet. A provider may submit notification on a Class Presentation Schedule, which appears in section 2105.16, if a course to be presented is pending approval and is submitted with a course approval application. The classroom must allow the instructor and students to communicate with a reasonable degree of privacy and without unreasonable distractions.

(d) An advertisement for an approved course must include the name of the provider, the provider number, the course title approved by the Department, the course number, the license type for which the course is approved and the credit hours assigned. A course advertisement may mention that the course has been approved for credit by the Department of Insurance or the Insurance Commissioner only if it has been approved in writing by the Department.

(e) A course advertisement may mention that the course has been submitted to the Department for approval only if a completed filing pursuant to Section 2105.5(a) was submitted to the Department at least thirty (30) days before the date the course will be presented to students for the first time and that the advertisement includes a notice, in at least the same size type as any language regarding the course having been submitted for approval, that the course is pending approval.

(f) A minor change to a course that does not affect course content or presentation time may be reported to the Department by a letter at least thirty (30) days before the change is to be implemented. A new edition of written material distributed to students with virtually identical content as an edition submitted when the course was approved may, in the Department's discretion, be considered a minor change.

(g) A major change to a course is one that affects presentation time or that alters the course content, and requires approval as a new course. The course approval application must be received by the Department at least thirty (30) days before the date the course will be presented to students for the first time. Use of different written materials is a major change, except as provided in subdivision (f).

(h) Notification of a cancellation, change in the location, date, or time of a previously submitted class schedule, or of an addition of a location, date or time must be submitted using electronic filing. The notification must be received by the Department at least ten (10) business days before the meeting of the rescheduled or relocated class or addition. The Department may accept late notification if accompanied by a letter, signed by the provider director, stating good cause. A provider may not at any time have a cumulative cancellation rate of more than 15 percent of its classes due to inadequate enrollment.

(i) Credit of less than one hour is not granted.

(j) Contact course credit hours are determined using a fifty (50) minute hour. A student may not receive credit for more than eight (8) hours per day or 400 minutes per day.

(k) Course subjects will be approved only if they sufficiently relate to the legal duties and responsibilities of a bail licensee, and they will be taught in a structured manner and environment that contributes to the professional or technical competence of the student

(*l*) Course subjects that do not qualify for approval include training in sales, marketing, communication, motivation, or products or programs offered by a specific surety.

(m) A provider may not state or imply that a course, including an approved course, is endorsed by the Department.

(n) If a scheduled class is cancelled, a provider must make a reasonable effort to notify all registrants of the cancellation, and maintain documentation of that effort.

(o) Credit will be given to a student who successfully completes an expired course if the course would have been renewed and the student was unaware that the course was expired.

(p) The Department may revoke approval of a course if the course content was significantly changed without prior notice to the Department and the change affects the number of hours that would have been assigned to the course, or the change in content would make the course ineligible for approval.

(q) Course approval will be valid for two (2) years from the date it is granted.

(r) For an Internet course, a provider must establish to the Department's satisfaction that the provider will employ adequate measures to ensure that students are actively engaged in course material for the entirety of the prescribed time, and such measures must actually be employed. The measures shall include, and a provider shall certify that it has included the following:

(1) the course must contain a minimum of 4,600 words for each hour of credit;

(2) the course examination time must total at least 10 percent and not more than 15 percent of the course completion time;

(3) the course must periodically pose questions and receive student answers before a student may proceed to the next screen;

(4) a final examination at the end of the course must contain a minimum of three questions for each credit hour;

(5) the time allocated for a student to spend on each page must not be excessive or inadequate;

(6) Internet course credit hours are determined using a sixty (60) minute hour.

(s) A Bail Course Approval/Renewal Application shall be accompanied by a declaration signed by the provider director stating that the course outlines were sent to the entities specified in Insurance Code section 1810.7(c). The declaration shall be accompanied by copies of the cover letters to the associations and all responses from the associations, if any. A provider will be deemed to have complied with the consultation requirement of Insurance Code section 1810.7(c) if either: (i) the provider submits responses from all of the associations; or (ii) thirty (30) days have passed from the date the provider sent the outlines to the associations and one or more associations has not responded.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.6. Course Renewal.

(a) A provider who wants to renew approval of an unchanged course or a course with only minor changes must submit to the Department a Bail Course Approval/Renewal Application, which appears as section 2105.15, along with the fee recited for Insurance Code sections 1751.1(d) and (f) listed in the Fee Schedule.

(b) A Bail Course Approval/Renewal Application must be received by the Department at least thirty (30) days before the expiration of the course's approval to maintain continuity of approval.

(c) A provider may not offer a continuing education course for credit if approval of the course has expired and the Department has not yet granted a renewal.

(d) The Department may deny renewal of course approval if the course material no longer contains current information.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.7. Maintenance of Records.

(a) A provider must maintain Prelicensing/Continuing Education Program Instructor Qualification Forms for each instructor.

(b) A provider must maintain records of registration for students attending approved courses. A provider must maintain address information and telephone numbers for each student of a prelicensing education course.

(c) For classroom courses, a provider must complete and maintain a daily attendance record, showing whether each student attended at the beginning and end of each class session. The attendance record must be on the Prelicensing/Continuing Education Program Course Attendance Record and Verification Form, which appears as section 2105.17, or on a form approved by the Department that contains the following minimum provisions:

(1) For prelicensing courses, the name, signature, and all or part of the social security number of the student as required by the Department. For continuing education courses, the name, original or electronic signature, and insurance license number of the student;

(2) provider name and approval number;

(3) course title and approval number;

(4) date and location of the class;

(5) the beginning and ending time of the session, and the time–in and time–out of each student.

(d) Provider records must be maintained for five (5) years and must be made immediately available to the Department for inspection and copying upon request. All provider records must be maintained at a location within this State unless a Prelicensing and Continuing Education Provider Stipulation to Maintain Records Outside of California, which appears as section 2105.18, has been submitted to and accepted in writing by the Department.

(e) A provider must maintain sufficient records to allow an accurate and reliable audit of all fees collected from and refunded to students for prelicensing and continuing education courses. These records must in-

clude, but are not limited to, bank statements, ledgers, journals, receipt books, invoices and checks.

(f) A provider must maintain for at least two (2) years a copy of each advertisement and solicitation that refers to a prelicensing or continuing education course. Upon good cause, the Department may require a particular provider to retain copies for a longer period.

(g) For a correspondence course, a provider must maintain a declaration signed by each student under penalty of perjury, under the laws of the State of California, declaring that the student was engaged with the course material for the entirety of the prescribed time.

(h) For an Internet course, a provider must maintain a description of the measures taken to ensure that students are actively engaged in the course material for the entirety of the prescribed time.

(i) A provider must employ all reasonable means to maintain personal information of students in a secure and confidential manner.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.8. Successful Completion of a Prelicensing Course.

(a) To obtain credit for a prelicensing course a student must attend one–hundred percent of the class.

(b) A provider or instructor must withhold credit when a student did not pay satisfactory attention, or otherwise failed to act acceptably in class.

(c) Prelicensing certificates of completion expire three (3) years from the completion date of the course, whether or not a license has been issued.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.9. Successful Completion of a Continuing Education Course.

(a) To obtain credit for a continuing education course a student must attend one–hundred percent of the class, if the course was provided in a classroom. However, an instructor or provider director may for good cause allow a student to attend not less than eighty (80) percent of a scheduled class and receive full credit. A provider or instructor must withhold credit when a student did not pay satisfactory attention, or otherwise failed to act acceptably in class.

(b) A course may not be taken for credit more than once during a renewal period.

(c) Successful completion of a continuing education course by means of the Internet or correspondence shall require the student to obtain a passing grade of at least seventy (70) percent on a written final examination. The final examination must be open book and must be graded by the approved provider. The provider must issue certificates of completion only to those students who have passed the final examination.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.10. Certificates of Completion.

(a) A provider must issue a certificate of completion to each student who successfully completes a prelicensing or continuing education course. A duplicate certificate of completion must be issued by a provider upon request in the case of a lost or destroyed certificate. A certificate of completion must contain the following information:

(1) an original signature of the instructor or provider director;

(2) the course title and approval number;

(3) the provider's name, address, telephone number and provider approval number;

(4) for classroom courses, the beginning date(s), the completion date, and the class location including street address, city, state, and zip code;

(5) the number of hours approved for the course;

(6) a statement that submitting a false or fraudulent certificate of completion to the Department may result in denial of a license application and revocation of a license;

(7) a statement that the student should retain the certificate for five (5) years.

(b) A provider must submit to the Department a provider roster using electronic filing within ten (10) business days following completion of a prelicensing course. A roster is to be submitted, using electronic filing, within thirty (30) calendar days following the completion of a continuing education course.

(1) Online provider roster filings must contain the following:

a. for prelicensing courses, the student's name and social security number; for continuing education courses, the licensee's social security number or license number, if any;

b. the course approval number, and course completion date;

c. for classroom courses, the start date(s) and zip code of the class location.

(2) Electronic provider roster filings must contain the following:

a. the provider approval number;

b. the student's name, social security number, or license number, if any;

c. the course approval number and completion date.

d. for classroom courses, the zip code of the class location.

(3) Flat File Format uploads using the ASCII flat file format. The ASCII flat file is a single line of information to record course credits for each student. The single line of information is 121 characters long. The following characters (numbers or letters) must be completed to allow the ASCII flat file information to be uploaded and recorded:

a. provider number, characters 1 to 9 (numbers only);

b. course number, characters 10 to 18 (numbers only);

c. course beginning date, characters 19 to 26 (mmddyyyy). If roster is for online course, space through characters 19 to 26);

d. course beginning time, characters 27 to 30 (military time). If roster is for an online course, space through characters 27 to 30);

e. course end date, characters 31 to 38 (mmddyyyy). If roster is for online course, space through characters 31 to 38);

f. course location zip code, characters 39 to 47, for contact courses only (non–contact courses enter 9 spaces);

g. student's social security number, characters 48 to 56 (numbers only). If the social security number is not provided, space to character 56;

h. student's last name, characters 57 to 91 (letters only). If the name has fewer characters, space to character 91;

i. student's first name, characters 92 to 106 (letters only). If the name has fewer characters, space to character 106;

j. student's middle name, spaces 107 to 121 (letters only). If the name has fewer characters, space to character to 121.

k. student's license number, spaces 122 to 128. If the license number is not available, space to character 128.

(4) "Comma Separated Values (CSV) format uploads using the CSV format. The CSV format is a tabular data format that has fields separated by the comma character (e.g. 123456,,,1234567,, 07152007,1000,07202007,99999,,,,,). The following characters (numbers or letters) must be completed to allow the CSV format file information to be uploaded and recorded:

a. the first line contains the provider number, a maximum of 9 characters (numbers only);

b. the second line contains the course number, a maximum of 9 characters (numbers only);

c. the third line contains the course beginning date, (mmddyyyy) for contact courses only. Insert a single comma if the roster is for an online course;

d. the fifth line contains the course beginning time (military time, hhmm) for contact courses only. Insert a single comma if roster is for an online course;

e. the sixth line contains the course end date (mmddyyyy) for contact courses only. Insert a single comma if roster is for online course;

f. the seventh line contains the course location zip code, for contact courses only. Insert a single comma if course is non–contact;

g. the eighth line contains the student's social security number (numbers only) if the student does not have a social security number, insert a single comma;

h. the ninth line contains the student's last name, (letters only), a maximum of 35 characters;

i. the tenth line contains the student's first name,(letters only, a maximum of 15 characters;

j. the eleventh line contains the student's middle name (letters only), a maximum of 15 characters;

k. the twelfth line contains the licensee's license number. If the student does not have a license number leave blank.

(5) Under special circumstances approved in advance by the Department, a provider may submit a typed or printed Provider Roster, form 446–13, as specified in section 2105.19. The roster must contain the following:

a. student's or licensee's name;

b. student's social security number for prelicensing courses; or

c. student's license number for continuing education courses, if any;

d. provider's name;

e. provider's approval number;

f. course name;

g. course approval number;

h. course credit hours;

i. course completion date;

j. for classroom courses, the start date, beginning time, end time, and classroom location including street address, city, state, and zip code;

k. signature of the provider director certifying the accuracy of the information provided

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.11. Enforcement.

(a) The Department may revoke or suspend approval of a provider, issue approval on a restricted basis, and/or impose a monetary penalty, if:

(1) A basis exists that would have authorized the Department to deny approval to the provider;

(2) the provider violated these regulations or applicable provisions of the Insurance Code;

(3) The provider failed to exercise reasonable care in evaluating the competency, good character, and integrity of an instructor; or

(4) The provider allowed another person to use the provider's approved provider status or course approval status.

(b) A provider whose approval is revoked or suspended, or upon whom a monetary penalty is imposed, must reimburse the Department for its costs of investigating and prosecuting the provider for the violation.

(c) Insurance Code section 1742 shall apply to providers. For such purposes, "approval" shall be interpreted the same as "license." When warranted, the Department may issue a restricted approval, or may revoke an unrestricted approval and issue a restricted approval in lieu thereof.

(d) A provider shall be considered a "subject person," and be chargeable as such pursuant to Insurance Code section 1748.5.

(e) An unapproved provider or person representing that provider who states or implies that the provider is approved shall be chargeable pursuant to Insurance Code section 12921.8 as if the provider were an unlicensed insurance agent.

(f) Insurance Code sections 1669 and 1738 shall apply to approval as a provider and to an application for approval as a provider.

(g) A provider must pay the below monetary penalties, plus any investigation and prosecution costs, for the following violations. The exiastence of this monetary penalty schedule does not preclude the Department from revoking or suspending the approval of a provider, in addition to or in lieu of imposing a monetary penalty, if the facts warrant. The Department may impose a monetary penalty without commencing a formal enforcement action pursuant to California Government Code sections 11500 *et seq.* However, if a provider upon whom such a penalty has been imposed requests a hearing within 10 business days of receiving written notice of the penalty, the Department must serve an Accusation pursuant to those sections or rescind the penalty. The fact that a violation is not recited in the below schedule does not mean that a monetary penalty, suspension or revocation may not be imposed by the Department.

Violation of Section	*Penalty*
Section 2105.3(a) — Provider approval	Automatic denial of any pending application for provider approval, and automatic denial of any application for provider approval filed within twenty four (24) months following the date on which course material was given to a student. Revocation of any approval already issued.
Section 2105.3(b) — Renewal of provider approval	A fine of one and one–half (1 1/2) times the amount of the course fees charged to all students completing courses provided after approval as a provider has expired and not yet been renewed, or $1,000 per course, whichever is more.
Section 2105.3(c) — Changes in provider information	$500 fine per failure to notify the Department of a change in provider information.
Section 2105.3(d) — Fictitious name	$10,000 total maximum fine for all uses of a particular unapproved fictitious name.
Section 2105.4(a) — Qualified instructor	$5,000 fine for each class taught by an instructor when either requirement of section 2105.4(a) has not been met.
Section 2105.4(b) — Use of disqualified instructor	Automatic revocation of provider's approval for permitting a person to act as an instructor after express disapproval by the Department.
Section 2105.5 — Course approval	A fine of one and one–half (1 1/2) times the amount of the course fees charged to all students for all courses for which the course had not been approved, or $1,000 per course, whichever is more.
Section 2105.5(c) — Notification to Department of classes	$500 fine for each violation.
Section 2105.5(d), (e) and (m) — Advertisement of courses	$500 fine for each violation of (d) or (e); $10,000 fine for each violation of (m).
Section 2105.5(g) — Approval of course with major change	A fine equal to 50 percent of the amount of the course fees charged to all students completing courses after a major change without Department approval, or $1,000 per course, whichever is more.
Section 2105.5(h) — Notification of class change	$500 fine for any violation.
Section 2105.5(i) and (j) — Credit	A fine equal to 50 percent of the amount of the course fees charged to all students completing courses in which credit is awarded in violation of subdivisions (i) or (j), or $1,000 per course, whichever is more.
Section 2105.5(n) — Class cancellation	$1,000 fine for each violation
Section 2105.6(c) — Expired courses	A fine equal to 50 percent of the amount of course fees charged to all students for all courses for which the course expired and not yet been renewed, or $1,000 per course, whichever is more.
Section 2105.7 — Maintenance of required records...	$100 fine per record for each failure to maintain a required record or provide it upon request to the Department.

Violation of Section	*Penalty*
Section 2105.8 — Credit	A fine equal to 50 percent of the amount of the course fees charged to all students completing courses in which credit is awarded in violation of subdivisions (a) or (b).
Section 2105.9(a) and (c) Successful completion of a continuing education course	A fine equal to 50 percent of the amount of the course fees charged to all students completing courses in which credit is awarded in violation of subdivisions (a) or (c).
Section 2105.10(a) — Certificates of completion.	$200 fine per certificate for each certificate that a provider fails to provide to a student who has successfully completed a course.
Section 2105.10(b) — Attendance rosters.	$500 fine per roster for each roster that a provider fails to submit on time to the Department using electronic filing.
Section 2105.3(e) — Course fees.	$1,000 fine for each student charged a course fee that deviates from the course fee schedule in effect at the time the student enrolled. $1,000 fine for each student charged a course fee based on a fee schedule that did not comply with a provision of section 2105.3(e).

NOTE: Authority cited: Sections 1812, 1813 and 1814, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.12. Department Prelicensing/Continuing Education Program Provider Certification/Renewal Application.

State of California
Prelicensing/Continuing Education Program
Provider Certification/Renewal Application
446-2 (Rev. 6/2006)

Department of Insurance

Producer Licensing Bureau – Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814-4309
www.insurance.ca.gov
Information (916) 492 - 3064

1.	Check one only: ☐ Original filing ☐ Renewal ☐ Change of Provider Director	Provider Number: _____	DEPARTMENT USE ONLY: Provider Number _____ Effective date: _____ BY: Date:
2.	Check one only: ☐ Continuing Education ☐ Prelicensing Education		
3.	Entity Type: ☐ Sole Proprietor SSN _____ ☐ Corporation FEIN: _____ ☐ Partnership FEIN: _____ ☐ Association FEIN: _____		
4.	Entity name:		
5.	Does the organization intend to use a fictitious (DBA) name? _____ Yes _____ No If YES, list such name: (Name must be approved by the Department prior to use)		
6.	Business Address*:	Number/Street (PO Box is not acceptable)	
		City/State/Zip	
	* If located outside of California, attach completed Form 446-40, Out-of-State Provider Jurisdiction Agreement.		
7.	Mailing Address:	Number/Street/PO Box	
		City/State/Zip	
8.	Phone Numbers:	Toll free ( ) Business ( ) Fax ( )	
9.	Record Storage Address**:	Number/Street (PO Box is not acceptable)	
		City/State/Zip	
	** If address is outside of California, attach completed Form 446-32, Stipulation To Maintain Records Outside of California.		
10.	Record Storage Contact Person:	Last First Middle	
		Business Phone ( ) Fax number ( )	

PROVIDER DIRECTOR: Individual within a provider organization with responsibility for the administration of the programs approved by the Commissioner pursuant to Sections 1749 and 1749.3, 1749.31 and 1810.7 of the California Insurance Code.

11.	Provider Director Name:	Last	First	Middle
12.	Residence Address:	Number/Street		
		City/State/Zip		
13.	Phone Numbers:	Residence ( )	Business ( )	Fax ( )
14.	E-mail Address:			
15.	Provider Director Qualifications (experience [i.e. insurance, teaching], professional designations, degrees, licenses held, etc.)			
16.	Is this organization now using or has it ever used any name other than listed in #4 or #5 above? _____ Yes _____ No If YES, list such names and dates used:			
17.	Has the organization submitted to the Department within the last year, a filing for which an approval has not been issued? _____ Yes _____ No If YES, list name under which the filing was made and date filed:			

COMPLETE THE AREA BELOW FOR YOUR ORGANIZATION TYPE. (Attach additional sheets if more space is needed.)

18. CORPORATE and ASSOCIATION APPLICANTS: Complete the following and attach a copy of the articles of incorporation or articles of association. If applicant is an admitted insurer and there has been no change in officers, directors or stockholders (any shareholder owning 10% or more interest in the organization) since the last official filing with the Department, you may attach a letter so stating in lieu of listing the officers, directors and stockholders below. If there has been a change, the following must be completed.

	Name: Last, First Middle	Residence Address	Social Security No. *
President			
Vice President			
Secretary			
Treasurer			
Director			
Director			
Director			
Stockholder			
Stockholder			

19. PARTNERSHIP APPLICANT: List name and address of all partners and attach copy of the partnership agreement. If no agreement, submit letter signed by all partners.

Partner Name: Last, First Middle	Residence Address	Social Security No. *

20. SOLE PROPRIETOR APPLICANT: List name and address of proprietor.

Name: Last, First Middle	Residence Address	Social Security No. *

*PERSONAL INFORMATION NOTICE: Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1997 (Civil Code Section 1798, et seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principle purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.2 of the IPA of 1997. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular.

21.	Is there any person within the organization, other than listed in question (18), (19), or (20), who acts in the capacity of a Controlling Person as defined in Section 1668.5 of the California Insurance Code, who possesses decision making authority in matters pertaining to prelicensing and/or continuing education? __ YES __ NO If YES, list name, residence address, and social security number of such person(s): attach a separate sheet if more space is needed. _____

22.	Has the organization or have any of its partners, members, controlling persons, officers, directors, or any shareholders owning a 10% or more interest in the organization, been the subject of any administrative agency disciplinary action? For the purpose of this question, administrative agency disciplinary action includes but is not limited to: having any professional, vocational or business license denied, suspended, placed on probation, restricted or revoked, or any fine imposed; withdrawing any application or surrendering any license to avoid disciplinary action; being issued a cease and desist order or its equivalent; being the subject of a conservation, liquidation, rehabilitation or receivership order. _____ YES _____ NO
23.	Has the organization or have any of its partners, members, controlling persons, officers, any shareholders owning a 10% or more interest in the organization, ever been convicted of a crime? _____ YES _____ NO "Crime" includes a felony or misdemeanor and military offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, having had any charge dismissed, expunged or plea withdrawn pursuant to Penal Code Section 1203.4, or having been given probation, a suspended sentence or a fine. You may exclude traffic citations and juvenile offenses.

IMPORTANT NOTE: If the answer is "YES" to question (22) or (23) above, attach a detailed statement, signed by an authorized person for the organization, listing the events which led to the charges (dates and places). If the matter was heard in court, attach copies CERTIFIED BY THE COURT of the Criminal Complaint and the Sentencing Minute Order showing the final plea, judgment and sentence. If any disciplinary action was taken by an administrative agency, attach a certified copy of the action.

24.	Is the organization registered with the Bureau for Private Postsecondary and Vocational Education? _____ Yes _____ No If YES, list approval number: _____
25.	Describe the organization's experience in offering educational programs to insurance licensees: Attach separate sheet if more space is needed.
26.	Provide a complete statement of your refund policy and describe how this policy will be transmitted to students before registration (submit sample):
27.	Indicate instruction method of courses to be offered: ☐ Contact (attendance required) ☐ Non-Contact (self-directed) ☐ Both Contact and Non-Contact
28.	For Contact courses, the following information is required: 1) Sample of attendance record forms proposed for use meeting the requirements sections 2105.7 (c) and 2188.5 (b) of California Code of Regulations. 2) Sample of Certificate of Completion (see section 2105.10(a) and 2188.8(a) of Tit. 10 California Code of Regulations).

29.	For Non-Contact courses, a statement providing the following information is required: 1) How long do students have to complete the course and how is that information transmitted to them? 2) What is your method for determining what date to use for course completion date and how is that information communicated to students? 3) Please supply information about protecting the integrity of the exam: who has control of the answer key(s); what is a passing grade; if someone fails the exam may they retake the exam and, if so, how many times and would it be the same exam; and do you return exams to students or discuss the answers with them? 4) Please enclose copy of your instruction sheet that goes to the student upon registration. 5) Sample of Certificate of Completion (see sections 2105.10(a) and 2188.8(a) of Tit. 10 California Code of Regulations).

CERTIFICATION

I agree to (a) maintain records of enrollments, attendance, exam grades and other pertinent information as requested by the commissioner for a period of five years (b) provide certificates of completion to those students who successfully complete courses (c) use only qualified instructors to conduct courses (d) timely provide the commissioner with completed course approval applications for programs submitted for credit approval, and (e) comply with the prelicensing and continuing education regulations and all applicable California Insurance Code sections. Further, I certify under penalty of perjury that I am the person who has responsibility for the administration of the operations contained in this application; that the information contained in this application is true and correct; and that no approved course will be offered for credit unless the organization holds an active provider approval status. Lastly, I understand that I must promptly report to the commissioner any changes in the information contained in this form.

Original Signature of Provider Director Date

Print name

FILING INSTRUCTIONS:

This form must be completed by each entity desiring to be certified or to renew certification as a prelicensing or continuing education provider.

Type or print clearly in ink. All sections of this form must be completed and submitted with proper attachments and filing fees to the Department.

Attach additional sheets if more space is needed to answer questions.

Please send this completed application, other required attachments and a NON-REFUNDABLE $64.00 filing fee as stated Section 1751.1 of the California Insurance Code on the Schedule of Fees to:

Make checks payable to:

California Department of Insurance
Producer Licensing Bureau - Education Section
P.O. Box 957
Sacramento, CA 95812-0957

Education Section Inquiries: (916) 492-3064

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8-20-2007; operative 9-19-2007 (Register 2007, No. 34).

§ 2105.13. Out-of-State Provider Jurisdiction Agreement.

State of California — Department of Insurance
Prelicensing/Continuing Education Program
Out-of-State Provider Jurisdiction Agreement
446-40 (Rev. 02/2001)

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814-4309
Information (916) 492-3064
www.insurance.ca.gov

INSTRUCTIONS:	DEPARTMENT USE ONLY:
* This form must be completed by every provider and provider applicant whose head office is located outside of California.	Provider Number _____ Date Received _____

Provider Number (if none, mark "pending"): _____ Date: _____

Provider Name: _____ Telephone: _____

Address:

_____
Street City State Zip

On behalf of the above named provider, I stipulate and agree:

(a) That in any action or special proceeding brought against the provider in the State of California, any document or process may be served on the commissioner with the same effect as though served upon the provider, and such service will give jurisdiction over the provider to the same extent as if the provider were a resident of the State of California.

(b) That any action or special proceeding brought by the provider against the Insurance Commissioner of the State of California will be brought in the City and County of San Francisco or in the County of Los Angeles.

(c) That the provider will appear at the Office of the Insurance Commissioner in the City of San Francisco or in the City of Los Angeles at any time, pursuant to notice of hearing, order to show cause, or subpoena issued by the commissioner, if such document is deposited in the United States mail, certified and postage prepaid, in a cover addressed to the provider at the last address filed by it with the commissioner, such deposit in mail being 31 or more days before the date specified in such document for such appearance, and that in the event of failure so to appear the provider hereby consents to recession or denial of provider certification by the commissioner.

PROVIDER DIRECTOR NAME_____
(Print or type)

PROVIDER DIRECTOR SIGNATURE: _____
DATE:_____

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8-20-2007; operative 9-19-2007 (Register 2007, No. 34).

§ 2105.14. Prelicensing/Continuing Education Program Instructor Qualification.

State of California
Prelicensing/Continuing Education Program
Instructor Qualification Form
446–4 (Rev. 06/2006)

Department of Insurance

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

INSTRUCTIONS
- This form must be completed by each proposed instructor, lecturer, moderator or person conducting a classroom course, seminar, workshop, conference, etc.
- Type or print clearly in ink.
- Provider Director must verify the information provided by the instructor.
- DO NOT SUBMIT THIS FORM TO THE DEPARTMENT. PLEASE RETAIN THIS FORM IN YOUR FILES FOR FIVE YEARS.
- Attach additional sheets if more space is needed to answer questions.

Provider Number: _____ Date: _____

Provider Name: _____ Telephone: _____

Address: _____
Street City State Zip Code

Instructor Name: _____ Residence Phone: _____

Residence Address: _____
Street City State Zip Code

List the course titles and course numbers to be taught:
Course Title Course Number

_____
_____

Describe your experience (3 years within the last 5 years) in the course subject matter:

_____
_____
_____

If you hold or have ever held an insurance license, complete the following:
License Type License Number State or Province Dates License Held From To

_____

If you have a college degree in the subject matter being taught, complete the following:
Name of College or University Course of Study Degree Date Completed

_____

Please indicate if you hold a recognized professional insurance designation and the date earned:

____ LUTC ____ CLU ____ AAI ____ CPCU ____ CIC ____ Other: _____

If you hold a recognized professional credential in the subject matter being taught, complete the following:
Type of Credential Credential Number Date Earned State or Province Issued

_____ _____ _____ _____

Have you ever been an instructor for another prelicensing or continuing education provider?

_____ YES _____ NO If YES, list the provider names, dates and reasons for leaving:

_____

Have you been the subject of any administrative agency disciplinary action? For the purpose of this question, administrative agency disciplinary action includes but is not limited to: having any professional, vocational or business license denied, suspended, placed on probation, restricted or revoked, or any fine imposed; withdrawing any application or surrendering any license to avoid disciplinary action; being issued a cease and desist order or its equivalent; being the subject of a conservation, liquidation, rehabilitation or receivership order. _____ YES _____ NO

Have you ever been convicted of a crime? _____ YES _____ NO

"Crime" includes a felony or misdemeanor and military offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, having had any charge dismissed, expunged or plea withdrawn pursuant to Penal Code Section 1203.4, or having been given probation, a suspended sentence or a fine. You may exclude traffic citations and juvenile offenses.

< IMPORTANT NOTE: If the answer is "YES" to either of the above two questions, attach a detailed statement, signed by you, listing the events which led to the charges (dates and places). If the matter was heard in court, attach copies CERTIFIED BY THE COURT of the Criminal Complaint and the Sentencing Minute Order showing the final plea, judgment and sentence. If any disciplinary action was taken by an administrative agency, attach a certified copy of the action.

INSTRUCTOR CERTIFICATION

I certify under penalty of perjury that the information contained in this application is true and correct and that nothing has been withheld which would influence a complete evaluation of my qualifications and conduct as an instructor.

I understand that this completed application will be maintained by the provider and made available to the commissioner as requested.

Original Signature of Instructor Date

PROVIDER VERIFICATION

I certify under penalty of perjury that I have reviewed and verified the qualifications of the instructor named above. To the best of my knowledge and belief, this person meets all of the checked qualifications per sections 2105.4 or 2188.1 of Tit. 10 California Code of Regulations. Note: Bail education instructors must satisfy the "three years experience" qualification. Other education instructors must satisfy at least one of the listed qualifications.

_____ Three years experience within the last five years in the course subject matter, which experience may include holding an appropriate insurance license for the subject being taught.

_____ Possession of a college degree in the subject matter being taught.

_____ Possession of a related recognized professional designation in the subject matter being taught.

_____ Possession of a related recognized professional credential in the subject matter being taught.

DO NOT SUBMIT THIS FORM TO THE DEPARTMENT. PLEASE RETAIN THIS FORM IN YOUR FILES FOR REVIEW DURING A PROVIDER AUDIT.

Original Signature of Provider Director Date

Printed Name of Provider Director

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.15. Bail Course Approval/Renewal Application.

State of California
Bail Course Approval/Renewal Application
LIC001B (Rev. 06/2006)

Department of Insurance

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

Instructions:	**Department Use Only:**
▪ This form must be completed for each course to be approved. ▪ A completed application with the proper attachments and filing fee must be received in the Department at least 30 days prior to the first course presentation. ▪ Courses must be a minimum of one hour; no fractional hours are granted.	Course #: _____ Approval period: _____ Credit Hours: _____ Category code: _____

First Course presentation dates:	Provider Number:	Phone Number: ( )

Provider Name:	
Address:	Street City State Zip
Course Title:* [Provide Course # if renewing course.]	

Check one course type:
☐ 12–hour Prelicensing ☐ Continuing Education: Number of Hours Requested: ____
Instruction Method:
☐ Contact
☐ Correspondence ☐ Internet

Number of times course to be given during approval period: ____ (for Internet courses, please mark approval period as N/A)	Include on Department's list of courses open to public? ☐ Yes ☐ No

Is the written proof of consultation attached pursuant to Section 1810.7 (c) of the California Insurance Code? If no, when will it be received by the Department?
☐ Yes ☐ No

For Department use only:

____ Course approved ____ Course **not** approved.

By: _____
Education Section Staff Signature Date

*Advertising and course materials must use this exact title. Courses based on another provider's material must be approved by that provider and must use same name.

REQUIRED ATTACHMENTS:

A. For Contact Courses:

1. ___ A detailed statement on how the course is relevant to bail topics and products.
2. ___ A detailed outline of approximately one page per hour of instruction including the time each topic is being presented.
3. ___ A copy of all materials presented to each student if a detailed outline is not submitted with application.
4. ___ An agenda showing the beginning and ending times, breaks, and time allotted for exams, if applicable.
5. ___ A completed Class Presentation Schedule form for each presentation.
6. ___ A current authorization letter from the author or publisher if using another vendor's source material as the basis for the course.
7. ___ California prelicensing curriculum and educational objectives with every line page–referenced to the source book(s) used. **(For Prelicensing Courses Only)**

B. For Correspondence or Internet Courses:

1. ___ A detailed statement on how the course is relevant to bail topics and products.
2. ___ Audio cassette, video tape, computer diskette, text book for the course or copy of the text cover, copyright page and table of contents if using another vendor's pre–approved material/book
3. ___ Internet courses must include your Internet address, security measures, log–on and password for our review of course(s). Answers to exam questions must reference section and screen for answer source.
4. ___ An examination with the questions not in chapter order.
5. ___ Answers to all exam questions with page and paragraph referencing to the source book(s) used.
6. ___ A current authorization letter from the author or publisher if using another vendor's source material.
7. ___ Copy of instruction sheet sent to students.
8. ___ For an Internet course, a description of the measures the provider will employ to ensure that students are actively engaged in course material for the entirety of the prescribed time.

CERTIFICATION:

I certify under penalty of perjury that I have read and understand the information and requirements contained in this application, that all statements are true and nothing has been withheld which would influence a complete evaluation of this course.

Original Signature of Provider Director Date

Printed Name of Provider Director

FILING INSTRUCTIONS:

This form must be completed by each entity desiring a bail course to be approved or renewed for prelicensing or continuing education.

Please send the completed application, other required attachments and the following NON–REFUNDABLE filing fee as stated Section 1751.1 of the California Insurance Code on the Schedule of Fees to:

California Department of Insurance
Producer License Bureau — Education Section
P.O. Box 957
Sacramento, CA 95812–0957

Filing Fees:
$32 per Continuing Education Course Approval
$64 per Prelicensing Education Course Approval
$13 per Continuing Education Course Renewal
$32 per Prelicensing Education Course Renewal

Make checks payable to:
California Department of Insurance

Attach additional sheets if more space is needed to answer questions.

Course applications must be received in this office at least 30 days prior to the first course presentation date. Course advertisements for pending courses must clearly state that the course has been submitted and is pending approval, if the course application is complete and submitted within the appropriate time frame.

Education Section Inquiries: (916) 492–3064

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.16. Class Presentation Schedule.

State of California
Class Presentation Schedule
446–12 (Rev. 11/2000)

Department of Insurance

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

Instructions:

- Type or print clearly. **USE A SEPARATE SHEET FOR EACH CLASS PRESENTATION.**
- To inform the Department of a new class, mark NEW box and provide all pertinent information below.
- To notify the Department of a change to a class schedule previously submitted, mark CHANGE, give the original date, time, location and provide new information below.
- To cancel a class previously submitted, mark CANCEL and complete information below.
- This completed form must be received by the Department at least 14 days prior to the original class presentation. Subsequent presentations must be received at least 10 days prior to class presentation. No faxes will be accepted.
- Late schedules may not be accepted and attendees may not receive continuing education credit.
- The information provided below must match the information on the certificate of completion and the provider roster.

CHECK ONE: New ☐ **Cancel** ☐ **Change** ☐ ≡ ≡

Original Date/Time:
Original Location:

Provider ID #:
Provider Name

Course ID#:	Credit Hours:	Instructor Name:	
Course Name:			
Start Date*:	Start Time:	End Date:	End Time:

Military Time **Military Time**

*If course spans more than one day, each day must be listed in Daily Presentation Schedule chart below.

Location of Presentation:

Street:	Room/Suite:	
City:	State:	Zip:

Daily Presentation Schedule: Times must be shown in military time (i.e. 8:00 AM = 0800; 2:00 PM = 1400)

Day	Date: (month/day/year)	Begin Time	End Time
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

(Attach sheet for additional days)

I certify that the class information provided here is true and correct to the best of my knowledge. Any changes will be provided to the Department promptly.

Original Signature of Provider Director Date

Printed Name of Provider Director (____) Phone Number

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.17. Prelicensing and Continuing Education Program Course Attendance Record and Verification Form.

State of California Department of Insurance
PRELICENSING/CONTINUING EDUCATION PROGRAM
COURSE ATTENDANCE RECORD AND VERIFICATION FORM
446–5 (Rev. 6/2006)

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

Course Number: _____

Course Title: _____

_____

Provider Number: _____

Provider Name: _____

_____

Class Location: _____
Street City State Zip Code

Class Date(s): _____

VERIFICATION:
I have reviewed and verified that the persons named on the attached Course Attendance Record Sheet(s), consisting of _____ pages, were present at this class during the times and days indicated.

Original Signature of Instructor *Date*

Printed Name of Instructor

CERTIFICATION:
I have reviewed this Course Attendance Record Verification and the attached Course Attendance Record Sheet(s), and certify that I find them accurate and in order, to the best of my knowledge.

Original Signature of Provider Director *Date*

Printed Name of Provider Director

COURSE ATTENDANCE RECORD SHEET

Provider #:	Provider Name:			Page of
Course #:	Course Name:			
Date:		Begin Time:	End Time:	Session of
Location:				Instructor:
	Street	City	State Zip	

NOTE: Those students who do not sign in and out will not be granted continuing education credit.

TIME–IN : AM/PM	PRINTED NAME (LAST, FIRST M.I.)	SOCIAL SECURITY NUMBER*	INDIVIDUAL INSURANCE LICENSE #	TIME–OUT : AM/PM	SIGNATURE I CERTIFY UNDER PENALTY OF PERJURY THAT THESE ARE MY CORRECT ATTENDANCE TIMES.

(ATTACH ADDITONAL SHEETS IF NECESSARY)

The Department requests disclosure of a student's social security number pursuant to Insurance Code Sections 1749, 1749.2, 1749.3, 1749.31, 1749.4, 1749.5, 1749.7, 1810.7 and CCR, Title 10, Chapter 5, Sections 2105.7(c)(1), 2105.10(b)(1), and 2188.5(b)(1). This information is requested so that the Department can properly identify and assign credit to students who have completed prelicensing or continuing education courses. While a student's disclosure of his or her social security number here is not mandatory, any failure to provide this information may delay or otherwise impede the Department in assigning credit for the completion of such courses to the appropriate students.

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.18. Prelicensing and Continuing Education Provider Stipulation to Maintain Records Outside of California.

State of California — Department of Insurance
Prelicensing and Continuing Education Provider
Stipulation to Maintain Records Outside of California
446–32 (Rev. 06/2006)

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

APPLICATION

The undersigned, as provider director of a prelicensing or continuing education provider duly authorized by the California Department of Insurance, has requested the Commissioner's authorization to maintain provider records at a location outside of California.

STIPULATION

In consideration of the Commissioner's granting of authorization to maintain the records described in California Code of Regulations, sections 2105.7 and 2188.4, at a location outside of California, the undersigned provider director, on behalf of the duly authorized education provider, agrees to reimburse the California Department of Insurance for the expense of travel for the Commissioner's agent to conduct routine records examinations. Any refusal by a provider to reimburse the California Department of Insurance shall constitute grounds for automatic termination of the Commissioner's authorization to maintain records outside of the state, and may also be considered in any subsequent hearing on the rescission of provider status. This agreement will remain in force concurrent with the provider's certification period.

PROVIDER NUMBER: _____

PROVIDER NAME:
(Print or type)

PROVIDER DIRECTOR NAME:
(Print or type)

PROVIDER DIRECTOR SIGNATURE: DATE:

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

§ 2105.19. Provider Roster.

State of California — Department of Insurance
Provider Roster
446–13 (Rev. 06/2006)

Producer Licensing Bureau — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

Important:. This form must be submitted to the California Department of Insurance (CDI) within **10 days** following the completion of the prelicensing course and 30 days following the completion of the continuing education or training course. **Late rosters may not be accepted.** *Items marked with an asterisk (*) are not required for non–contact courses.*

Pre–licensing Course: ☐ Continuing Education Course: ☐

Contact course: ☐ Non–Contact course: ☐*

Provider ID #: Provider Name:

Course ID #: Credit Hours: Course Name:

*Course Start Date: *Beginning Time: *End Time: Completion Date:
Military time (i.e. 1300 = 1:00 P.M.)

*Class location:

Street Address Suite/Room

City State Zip Code

The Department requests disclosure of a student's social security number pursuant to Insurance Code Sections 1749, 1749.2, 1749.3, 1749.31,1749.4, 1749.5, 1749.7, and 1810.7 and California Code of Regulations, Title 10, Chapter 5, Section 2105.10 (b) (1) through (7) and 2188.5 (b)(1). This information is requested so that the Department can properly identify and assign credit to students who have completed prelicensing or continuing education courses. While a student's disclosure of his or her social security number here is not mandatory, any failure to provide this information may delay or otherwise impede the Department in assigning credit for the completion of such courses to the appropriate students.

ALL ENTRIES MUST BE TYPED.

#	Social Security Number	Licensee Name: Last, First M.I.	Individual License #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please use backside for additional names.

Certification

I have reviewed this Provider Roster and the associated Course Attendance Records or examination information and certify to the best of my knowledge that the individuals listed here meet the requirements for credit.

Original signature of Provider Director Date ( ) Phone

Printed Name of Provider Director

PROVIDER ROSTER (continued) Page 2

All entries must be typed.

#	Social Security Number	Licensee Name: Last, First M.I.	Individual License #
16.			
17.			
18.			
19.			
20.			
21			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
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39.			
40.			
41.			
42.			
43.			
44.			
45.			
46.			
47.			
48.			
49.			
50.			

NOTE: Authority cited: Section 1812, Insurance Code. Reference: Section 1810.7, Insurance Code.

HISTORY

1. New section filed 8–20–2007; operative 9–19–2007 (Register 2007, No. 34).

Article 3. Motor Vehicle Insurance

BASIC PRINCIPLES

§ 2107. Prevention of Fraud; Statement to Purchaser.

All questions involving violation or alleged violation of these rules and regulations or of the provisions of the Insurance Code applicable to the transaction of insurance in connection with sales of or loans on motor vehicles will be viewed by the commissioner upon the basis of whether or not as to each such question there has been any violation of the following principles:

(a) The purpose of the rules and regulations is to prevent fraud or the transaction of insurance covering motor vehicles, where the premiums for such insurance are included in the purchase price or the amount loaned upon security of a motor vehicle.

(b) To accomplish this purpose it is necessary that in connection with such a transaction the purchaser or borrower receive at the time of the execution of the contract either a written statement conforming to Section 2114 or all of the information required to be placed in such statement in the manner and form permitted by Section 2114.5. The responsibility for delivery of such statement or for the transmittal of the information required to be placed in the statement and otherwise complying with Section 2114.5 rests upon the licensee who transacts the insurance involved.

NOTE: Authority cited for §§2107 to 2127: Section 383.5, Insurance Code.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2108. Relation to Specific Rules.

The above basic principles shall govern in all matters relating to these rules and regulations. Specific rules are hereinafter set forth for the purpose of facilitating the application of the basic principles and are not to be used for the purpose of voiding or defeating these basic principles.

DEFINITIONS

§ 2109. Terms Defined; Rules for Construction.

For the purpose of the basic principles and rules and regulations, unless the context otherwise requires,

(a) "Motor vehicle insurance transaction" means

(1) Any sale of a motor vehicle which includes in the cash or time selling price of such motor vehicle a premium for insurance covering any interest therein, and

(2) Any loan where the security for the repayment for all or any portion thereof is a lien or encumbrance upon a motor vehicle and which includes in the amount involved in a loan agreement, chattel mortgage or other lien instrument a premium for insurance covering any interest of the borrower or mortgagor therein.

(b) "Dealer" means any person who

(1) As seller or lender enters into motor vehicle insurance transactions as a business, or

(2) Who discounts or purchases contracts of sale and receives for its own use and benefit, either directly or indirectly, a commission on the insurance included therein.

(c) "Dealer's Subsidiary" means any person duly licensed by the Department of Insurance who transacts insurance covering a motor vehicle which is the subject matter of a motor vehicle insurance transaction, where such insurance is not lawfully transacted by a duly licensed dealer.

(d) "Licensee" means any person licensed by the Department of Insurance to transact insurance, including a duly licensed dealer or a dealer's subsidiary.

(e) "Purchaser" includes borrower or mortgagor.

(f) "Contract of sale" includes conditional sales contracts, loan agreements, financing agreements, chattel mortgages or other lien instruments, or any revision thereof, made in conjunction with a motor vehicle insurance transaction.

(g) "Insurance coverage" includes "dual" and "single interest" insurance and any coverage in which the dealer acts as insurer or self–insurer.

(h) "Gross premium" means the charge made to the purchaser for insurance coverage without deduction for commissions.

(i) "Gross return premium" means the gross premium unearned as of the date of cancellation of the insurance contract.

(j) "Unlawful rebate" includes the acts denounced by Sections 750 to 761 of the Insurance Code.

(k) "Dealer's reserve" means that portion of the difference between the cash balance and the contract balance which is earned or given to the dealer and retained by the person purchasing or discounting the contract of sale as collateral security for any contingent liability of the dealer.

(*l*) "Bonus" means a dealer's reserve which is earned or given to the dealer by the person purchasing or discounting the contract of sale, and not held as collateral security for any contingent liability.

(m) Insurance Code Sections 11, 12, 13, 16, 19, 20, 22, 23 govern the construction of these rules and regulations. These rules and regulations are applicable to Vendor's Single Interest Insurance of all kinds.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

REGULATIONS

§ 2110. License Requirements; Dealer.

Every dealer who enters into a motor vehicle insurance transaction shall be licensed to transact insurance as an agent or broker, or both, unless he receives no commission dealer's reserve or bonus dependent directly or indirectly upon insurance and the insurance is personally transacted by a dealer's subsidiary or other licensee.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2111. Same; Appointment by Insurer Required for Agent.

Dealers and dealers' subsidiaries who are licensed as agents only shall not transact insurance, directly or indirectly, which is placed with an insurer unless, at the time of the transaction, there is on file with the commissioner a document executed by the insurer or its authorized representative appointing them its agent in this State.

HISTORY

1. Amendment filed 9–3–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2112. Same; When Required of Employee.

Every employee or salesman of a licensed dealer or dealer's subsidiary shall be licensed to transact insurance unless

(a) He is a regularly salaried administrative or clerical employee who devotes substantially all of his services to activities other than the solicitation of insurance from the insuring public and receives no commission on insurance, directly or indirectly, or

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(b) He devotes substantially all of his activities to selling merchandise and his solicitation of insurance is limited *only* to the quoting of a premium for insurance, to be included in the purchase price, covering the interest retained in such merchandise by the dealer, and he receives no commission on insurance, directly or indirectly.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2113. Responsibility of Licensee for Employees.

Every licensed dealer and dealer's subsidiary is responsible for violations of the Insurance Code committed by his employees and salesmen and permitted by him.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2114. Written Statement to Purchaser.

Except as permitted by Section 21145 every licensed dealer or dealer's subsidiary shall at the time of the execution of a contract of sale deliver to the purchaser a written statement signed by both the purchaser and the dealer or dealer's subsidiary as the case may be. Such statement shall be denominated a "Statement of Insurance" and shall be either a separate document or a separately executed portion of another document connected with the motor vehicle insurance transaction. If any provision of any law of this State requires that any matters specified herein be included in another document connected with such transaction their inclusion therein shall be deemed compliance with this section. A copy of the Statement of Insurance and of such other document, if any, shall be retained by the dealer or dealer's subsidiary in the records and files of his insurance transactions. The printed portion of the Statement of Insurance shall be in type not less than ten point unless it is included in the same document as a conditional sales contract as defined in Section 2981 of the Civil Code, in which event it shall be printed in not less than eight point. All inserts made to complete such Statement must be equally prominent and must be made prior to the signing thereof by any party. Such Statement of Insurance shall specify the following facts relative to all insurance charged to the purchaser or placed upon the motor vehicle referred to in the contract of sale.

(a) The kind of insurance coverage. If there be no insurance covering an interest of the purchaser, a clear statement of that effect must be included. If there be no insurance against damages resulting from the ownership or operation of the vehicle arising by reason of personal injury to or the death of any person, or from damage to property, a statement must be included reading:

"UNLESS A CHARGE IS INCLUDED IN THIS AGREEMENT FOR PUBLIC LIABILITY OR PROPERTY DAMAGE INSURANCE, PAYMENT FOR SUCH COVERAGE IS NOT PROVIDED BY THIS AGREEMENT."

(b) The amount of the gross premium for each kind of insurance coverage and the aggregate gross premium for all such insurance coverage.

(c) The term of such insurance coverage. In the event the term of any insurance coverage expires prior to or continues after the expiration date of the contract of sale, that fact shall be clearly stated.

(d) A notice reading substantially as follows:

"NOTICE. No person is required as a condition precedent to financing the purchase of an automobile that any insurance be negotiated or purchased through a particular insurance agent or broker."

HISTORY

1. Amendment filed 9–5–61; designated 1–1–62 (Register 61, No. 18).

§ 2114.3. Written Statement; on Revision or Correction of Contract.

If a contract of sale be revised or corrected after its original execution and at a time when the purchaser is not present at the premises of the dealer the requirement of Section 2114 with respect to the signing of the Statement of Insurance by the purchaser shall be deemed complied with if the dealer promptly mails to the purchaser at his last known address two signed copies of said statement with a request to the purchaser that he execute and return one of them.

HISTORY

1. New section filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2114.5. Written Statement; Transaction by Dealer's Subsidiary.

If the insurance is transacted by a dealer's subsidiary the information required to be contained in the Statement of Insurance may be given by the dealer's subsidiary to the purchaser as provided in this section if all the following requirements are met:

(a) The dealer's subsidiary has in his possession blank Statement of Insurance forms in which all of the information required by Section 2114 may be inserted.

(b) There is as a part of the transaction oral communication between the purchaser and the dealer's subsidiary either person to person or by telephone in which:

(1) The dealer's subsidiary ascertains that the purchaser has in his possession and before him at the time of such conversation a blank Statement of Insurance form which, if properly completed, will include all the information required by such section.

(2) The dealer's subsidiary secures from the purchaser all facts necessary to the underwriting and rating of the insurance.

(3) The dealer's subsidiary gives to the purchaser all information required to be set forth in the Statement of Insurance pursuant to such section and records the information given in his own Statement of Insurance form.

(c) The dealer's subsidiary on the same or next business day mails to the purchaser and to the motor vehicle dealer copies of the Statement of Insurance signed by him and keeps a record thereof in the records referred to in Section 2116.

HISTORY

1. New section filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2114.7. Duty of Licensee in Quotation of Rate.

Every dealer or dealer's subsidiary shall use due care in obtaining full information necessary to the quotation of the rate for the insurance and in the quotation of such rate. No dealer or dealer's subsidiary shall knowingly or willfully make any misquotation of premium or rate nor quote a premium or rate for a particular kind of insurance or for a particular insurer without a reasonable expectation that such kind of insurance at the rate quoted can be lawfully procured by him from such insurer.

HISTORY

1. New section filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2115. Licensee to Compare Statement and Policy and Make Adjustment.

Every dealer or dealer's subsidiary shall, within a reasonable time after entering into a motor vehicle insurance transaction

(a) Compare the gross premium, insurance coverage and the term thereof set forth in the statement referred to in Section 2114 with the policy or certificate of insurance issued by the insurer.

(b) Shall adjust the coverage and term in the policy to conform to the statement described in Section 2114 by securing any necessary endorsement from the insurer, and

(c) Shall adjust any difference in the premium by making a refund or additional charge, as the case may be, to the purchaser so that the charge for the insurance coverage as contained in the statement referred to in Section 2114 conforms to the premium set forth in the policy or certificate of insurance. To the extent that Chapter 2b of Division 3 of Part 4 of Title 14 of the Civil Code prescribes the procedure, time or amount of such charges or refunds they shall be governed thereby. Otherwise any refund herein referred to may be made only in the following ways:

(1) By cash or check, immediately,

(2) By crediting the next payments due on the purchaser's contract of sale, or

(3) By crediting the last payments due on the purchaser's contract of sale; in which event such refund shall include a refund of all finance, in-

terest, time price differential, service charges or other fees properly allocable to the amount of the refund from the inception of the contract.

(4) If the contract of sale has been assigned, sold or transferred, by payment to the holder thereof with instructions to credit or pay the refund in any one of the three preceding alternative ways.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2116. Maintenance of Separate Record; Contents.

Every licensed dealer or dealer's subsidiary shall maintain, separate from the records of other business transactions, a ledger, book or card record of insurance business transacted under the authority of his license, which shall set forth at least the following information:

(a) Name of insurer.

(b) Policy or certificate number.

(c) Name of insured and of purchaser.

(d) Effective and termination dates.

(e) Kind of coverage.

(f) Amount of gross premium.

(g) Amount of commission.

(h) Amount of net premium.

(i) Date of cancellation.

(j) Amount of gross return premium and disposition thereof.

(k) Any addition or reduction in original premium by reason of endorsement.

(*l*) Names of persons to whom commissions are paid or allowed and the amount to each.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2117. Record Required of Insurance Not Included in Vehicle Transaction.

Every licensed dealer or dealer's subsidiary who transacts insurance where the premium is not included in a motor vehicle insurance transaction shall maintain, in addition to the data contained in Section 2116, the following additional information:

(a) Date of payment of premium by insured.

(b) Date of payment of premium to insurer.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2118. Purchase of Contracts Restricted.

Licensees shall not purchase, finance or discount contracts of sale which include a charge, either directly or indirectly, for insurance or as to which insurance exists for the benefit of the purchaser or licensed dealer, from any dealer who is not licensed by the Department of Insurance unless such insurance was lawfully transacted.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2119. Insurance Through Unlicensed Dealers; Placing by Licensee Prohibited.

Licensees shall not place insurance coverage in conjunction with motor vehicle insurance transactions, either directly or indirectly, at the request of any dealer who is not properly licensed.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2120. *Same; Duty of Licensee to Investigate.*

Licensees shall not place insurance coverage in conjunction with motor vehicle insurance transactions, either directly or indirectly, which was not solicited or negotiated by such licensee unless he first determines that such insurance was solicited or negotiated by a properly licensed dealer.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2121. Same; Commission Payment to, Prohibited.

The paying or allowing of any commission or other valuable consideration on insurance by any insurer or licensee to an unlicensed dealer or to a licensee in connection with insurance which was not lawfully transacted by him, by crediting the dealer's reserve or by paying a bonus, or otherwise, constitutes an unlawful rebate.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2121.5. Duty of Licensee; Remission of Premium; Refund of Finance Charge.

No licensed dealer or dealer's subsidiary shall enter into or proceed under any contract, agreement or other arrangement under or pursuant to which any premium for insurance which is included in the unpaid balance of any contract of sale is not remitted to the insurer or person entitled thereto within 90 days after the execution of such contract.

If such premium or the net portion due is not so actually remitted to such persons within said 90 days the licensed dealer or dealer's subsidiary shall be responsible for the refund to the purchaser of the finance, interest, time price differential, service charge or any other fee based upon such premium for any period prior to its actual remission. Such refund shall be made in the same manner as is provided for a refund in Section 2115.

HISTORY

1. New section filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2122. Return Premium; Account to Purchaser.

Every licensed dealer or dealer's subsidiary who, in connection with a motor vehicle transaction, effects the cancellation of an existing insurance policy pursuant to written authority from the purchaser and takes from the purchaser an assignment of the return premium thereon, or who, in connection with such transaction, takes from the purchaser an assignment of any return premium which may develop upon a future cancellation shall, in either event, upon such cancellation apply the full amount of the gross return premium toward the purchase of replacing insurance required by the contract of sale; except that if the amount thereof be in excess of the amount required for replacing insurance, if there be no replacing insurance or if the premium for such replacing insurance is not included in any contract of sale, such excess or such gross return premium, as the case may be, shall be refunded to the purchaser in one of the following ways:

(1) By cash or check, immediately,

(2) By crediting the next payments due on the purchaser's contract of sale, or

(3) By crediting the last payments due on the purchaser's contract of sale; in which event such refund shall include a refund of all finance, interest, time price differential, service charges or other fees properly allocable to the amount of the refund from the date of such cancellation.

(4) If the contract of sale has been assigned, sold or transferred by payment to the holder thereof with instructions to credit or pay the refund in any one of the three preceding alternative ways.

HISTORY

1. New section filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2123. Same; Form of Assignment to Dealer.

The assignment referred to in Section 2122 shall be in writing and shall contain, in substance, the following provision:

"In consideration of allowing me credit for the full amount of the gross return premium on Policy No. _____ covering my 19 ____ automobile, I hereby assign to _____ all my right, title and interest in and to such return premium."

A signed copy of such assignment shall be retained by the person taking the assignment in the records and files of his insurance transactions.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2124. Refund or Additional Charge Less Than $1.00 Waived.

If the total amount of any refund or additional charge required by any provision of this article is less than $1.00 no licensee is in violation of this article if he fails to make such refund or charge.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2125. Duty to Deliver Policy or Certificate.

(a) Where an insurer executes a policy or certificate evidencing insurance and delivers the original or a true copy thereof to a dealer, dealer's subsidiary or other licensee, for transmittal to the purchaser or owner, it shall be the duty of said dealer, dealer's subsidiary or other licensee to deliver such original or copy to the purchaser and to each owner of the motor vehicle.

(b) Where insurance coverage is evidenced by a policy or certificate executed by a dealer, dealer's subsidiary or other licensee duly authorized pursuant to Chapter 5, Part 2, Division 1 of the Insurance Code, it shall be the duty of said dealer, dealer's subsidiary or other licensee to deliver the original or a true copy thereof to the purchaser and to each owner of the motor vehicle.

HISTORY

1. Amendment filed 9–5–61; designated 1–1–62 (Register 61, No. 18).

§ 2126. Compliance Required in Addition to Insurance Code.

Compliance with these rules and regulations is not exclusive but is required in addition to compliance with any and all provisions of the Insurance Code.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

§ 2127. Penalties.

A violation of this article constitutes a violation of Insurance Code Section 383.5 and is grounds for the suspension, revocation or denial of licenses issued by this Department in accordance with the provisions of the Insurance Code relating thereto.

HISTORY

1. Amendment filed 9–5–61; designated effective 1–1–62 (Register 61, No. 18).

Article 3.5. Rental Car Agent Licensing Regulations

§ 2130. Authority.

These regulations are promulgated pursuant to the authority granted the Insurance Commissioner by the California State Legislature under the provisions of Assembly Bill No. 62 (Stats. 1999, Ch. 618). On and after January 1, 2001, no rental car company may sell or offer insurance without complying with Sections 1758.8–1758.891 of the Insurance Code and these regulations.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Sections 1758.8–1758.891, Insurance Code.

HISTORY

1. New article 3.5 (sections 2130–2130.8) and section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repeal of article 3.5 (sections 2130–2130.8) and repeal of section by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New article 3.5 (sections 2130–2130.8) and section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repeal of article 3.5 (sections 2130–2130.8) and repeal of section by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New article 3.5 (sections 2130–2130.8) and section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealer of article 3.5 (sections 2130–2130.8) and section by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New article 3.5 (sections 2130–2130.8) and section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order, including amendment of section and NOTE, transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.1. Definitions.

As used in these regulations and in Article 16.6 (commencing with Section 1758.8) of the Insurance Code:

(a) "Authorized insurer" means an insurer holding a California certificate of authority that includes the kinds of insurance enumerated in Section 1758.85 of the Insurance Code.

(b) "Franchise" and its derivatives are as defined in the California Corporations Code, Title 4, Division 5, Part 1 (commencing with Section 31005).

(c) "Organization" means a partnership, limited liability company, association, or corporation. Where reference is made to a natural person named on an organization license, the reference shall be to a person who is named to exercise the power and perform the duties under an organization license.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Sections 1628 and 1758.85, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.2. Applications.

(a) A separate license shall be applied for and obtained by each natural person (i.e., individual) or organization that intends to act as a rental car agent.

(1) An individual licensee may own or act as the franchisee of more than one rental car company without obtaining additional licenses.

(2) An organization licensee may act as the franchisee of more than one rental car company without obtaining additional licenses.

(b) An individual or organization licensee shall file with the Commissioner any true name or fictitious name(s) under which the applicant intends to act as a rental car agent. The Commissioner may disapprove, in writing, the use of any true or fictitious name (other than the bona fide true name of an individual) by any licensee pursuant to Section 2050 et seq. of this chapter.

(c) Any certification required in Article 16.6 (commencing with Section 1758.8) of the Insurance Code shall be made under penalty of perjury under the laws of the State of California.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Sections 1758.8, 1758.82 and 2050 et seq., Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No.

49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.

2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.3. Fees.

(a) A fee of $340 shall be paid at the time the license application is filed.

(1) Applications that are not accompanied by the appropriate fee shall not be accepted for filing, whether or not they contain all the documents otherwise required by Sections 1758.81(a) and 1758.82(c) of the Insurance Code.

(b) A fee of $340 shall be paid at the time a rental car agent license renewal is filed.

(c) Costs charged by the Department of Insurance for any enforcement action or investigation shall be paid by the licensee, in addition to the application or renewal filing fee.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Section 1758.81, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).
9. New subsection (b) and subsection relettering filed 8–19–2002 as an emergency; operative 8–19–2002 (Register 2002, No. 34). A Certificate of Compliance must be transmitted to OAL by 12–17–2002 or emergency language will be repealed by operation of law on the following day.
10. Reinstatement of section as it existed prior to 8–19–2002 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).
11. New subsection (b) and subsection relettering filed 3–6–2003; operative 4–5–2003 (Register 2003, No. 10).

§ 2130.4. Disclosure.

(a) The brochures or other written materials that are provided to the prospective renter pursuant to Section 1758.86 of the Insurance Code shall include, among other information:

(1) the approved true or fictitious name under which the licensee is doing business at the location in which the rental transaction is taking place;

(2) the name(s) of any insurer(s) providing the insurance being offered to the prospective purchaser.

(b) All disclosures required by Section 1758.86(b) of the Insurance Code and these regulations shall be written clearly and conspicuously.

(c) A copy of the rental agreement shall be provided to the renter at the time of execution of the rental car contract.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Section 1758.86, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.5. Training.

(a) A separate set of training materials shall be prepared and submitted to the Commissioner for each insurance product sold.

(1) If endorsees of a single licensee doing business under the same name at multiple locations are selling the same insurance product, no more than one set of training materials shall be prepared and submitted to the Commissioner for that product.

(2) Insurance products provided by different insurers shall be deemed to be different products for the purpose of these regulations.

(b) Training of endorsees shall be conducted whenever there is a change in the insurance product(s) sold, but in no event less frequently than every two (2) years.

(c) If the training materials have been developed by an insurer and approved by the California Department of Insurance, the applicant is not required to submit the training material. The applicant instead shall submit a letter, signed by both an authorized representative of the insurer and by the applicant (or officer of the entity), stating that the applicant will use the approved training materials filed by the insurer.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Section 1758.82, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).

7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.6. Records.

(a) Records of insurance transactions and other documents required by Article 16.6 (commencing with Section 1758.8) of the Insurance Code and these regulations shall be maintained for at least three (3) years after the expiration or cancellation date of the policy to which the records pertain, except where otherwise specifically authorized by statute or the Commissioner.

(b) Records shall be kept in this State, in the principal office of the licensee, except where otherwise specifically authorized by statute or the Commissioner.

(c) Records shall be produced for examination by the Commissioner or a designee of the Commissioner within 30 days of the mailing date of a written request. Records may be requested in electronic or written format.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Section 1758.82, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order, including amendment of subsection (c), transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.7. Forms.

The specific forms required to be filed with the Commissioner by license applicants and licensees are as follows:

(a) The written application for licensure shall be made on Form 441–9 (Rev 11/2000) for individuals and on Form 441–11 (Rev 11/2000) for organizations.

(b) The initial certification of authorized employees shall be made on form Lic. RCA 1 (Rev 11/2000).

(c) The annual certification of authorized employees shall be made on form Lic. RCA 2 (Rev 11/2000).

(d) The insurer certification shall be made on form Lic. RCA 3 (Rev 11/2000).

(e) Training materials submitted to the Commissioner shall contain all of the elements set forth in form Lic. RCA 4 (Rev 11/2000).

(f) The list of authorized endorsees shall be made on form Lic. RCA 5 (Rev 1/2000). The list shall be maintained in a format capable of transmission to the Commissioner electronically and in hard copy or diskette, however requested by the Commissioner pursuant to Section 2130.6(c) above. The electronic version shall be transmitted in commercial word–processing or spreadsheet form. When requested, the list shall be updated to include endorsees newly authorized up to 30 days before the mailing date of the request, and shall include the dates upon which each endorsee's authorization began and, if relevant, terminated. It shall then be transmitted as an attachment to e–mail or by regular mail in hard copy or diskette, as requested. The appropriate e–mail and regular mailing addresses shall be posted by the Department on its website at http://www.insurance.ca.gov.

(g) All forms set forth in this subsection are incorporated herein by reference in their entirety and are available upon request, by telephone or in writing, to the Department of Insurance or on the website of the Department of Insurance, at www.insurance.ca.gov.

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Sections 1758.81 and 1758.82, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).
5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order, including amendment of subsection (f), transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

§ 2130.8. Procedures.

(a) The following criteria shall apply to procedures employed by the Commissioner in considering and issuing licenses:

(1) If the application is deficient, the Commissioner shall, within twenty–one (21) calendar days of receipt of the license application, inform the applicant, in writing, that the application is deficient and what specific information is required for completion.

(2) The Commissioner shall, within thirty (30) calendar days of filing of a completed application, reach a decision whether to issue or deny a license, and shall notify the applicant of the decision. If the Commissioner has decided to deny the application, the reason(s) therefor shall be set forth in the notification.

(b) The periods set forth above shall be tolled in the event the application requires legal action by the Commissioner.

(c) The Department of Insurance's median, minimum and maximum times for processing a license from the receipt of the initial completed application to the final license decision, and excluding applications that require legal action by the Commissioner, are as follows:

(1) thirty (30) calendar days (median time),

(2) fourteen (14) calendar days (minimum time), and

(3) one (1) calendar year (maximum).

NOTE: Authority cited: Section 2, A.B. 62 (Stats. 1999, c. 618). Reference: Section 15376, Government Code; and Section 1670, Insurance Code.

HISTORY

1. New section filed 12–6–2000 as an emergency; effective 12–6–2000; operative 1–1–2001 pursuant to Insurance Code section 1758.891 (Register 2000, No. 49). A Certificate of Compliance must be transmitted to OAL by 4–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 18).
3. New section filed 4–30–2001 as an emergency; operative 4–30–2001 (Register 2001, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–28–2001 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2001, No. 39).

5. New section filed 9–25–2001 as an emergency; operative 9–25–2001 (Register 2001, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–23–2002 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
7. New section filed 1–31–2002 as an emergency; operative 1–31–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–31–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–31–2002 order transmitted to OAL 2–6–2002 and filed 3–21–2002 (Register 2002, No. 12).

Article 4. Surplus Lines

LICENSEES OTHER THAN SURPLUS LINE BROKERS

§ 2131. Misrepresentation by Licensee to Surplus Line Broker.

(a) Any person licensed by the Insurance Commissioner who misrepresents, to any surplus line broker, any material fact regarding insurance coverage, or misrepresents to such surplus line broker facts with regard to the rules of submission or rates, or in any way conspires to procure nonadmitted insurance in violation of the law or of the basic principles herein set forth, will subject himself to action in respect to his license as provided by Section 1731 of the Insurance Code. (Ins. C. 1760.5.)

(b) This rule relating to other licensees shall not relieve the surplus line broker of his duty under the law.

NOTE: §§2131 to 2172, inclusive, issued under authority contained in Section 1763, Insurance Code. The source of §§2050 to 2324, inclusive, is the Rules and Regulations, Insurance Commissioner.

BASIC PRINCIPLES

§ 2132. Preference to Admitted Insurers; Collection of Tax.

All questions involving violation or alleged violation of the Surplus Line Brokers' Act, Chapter 6, Part 2, Division 1, Insurance Code, hereinafter referred to as the "Act," will be viewed by the commissioner upon the basis of whether or not as to each such question there has been any violation of the following basic principles:

(a) The Act is designed to grant a preference to insurers admitted to do business in this State, with the specific exceptions contained therein, and insurance coverage may not be solicited for, or contracts of insurance placed with, any nonadmitted insurer, unless and until such coverage is not procurable from a majority of the admitted insurers holding certificates of authority to transact the class or classes of insurance involved in such insurance contracts.

(b) The act is designed only to provide a medium through which citizens of this State may obtain from nonadmitted insurers coverage not readily procurable from admitted insurers.

(c) The act requires the collection of a tax upon premiums for insurance placed with nonadmitted insurers.

The above basic principles shall govern in all matters relating to the act. General and specific rules are hereinafter incorporated for the purpose of facilitating the application of the basic principles, and are not to be used for the purpose of avoiding or defeating these basic principles.

SUBMISSION RULES

§ 2133. Submission to Admitted Insurers: "Class" Defined.

Submission to admitted insurers is always required except as hereinafter expressly otherwise stated.

Forms of Coverage. ("Class" means the classes enumerated and defined in Sections 100 to 120, inclusive, of the Insurance Code).

§ 2134. Not Unprocurable If Admitted Insurer Cannot Lawfully Issue.

No insurance will be deemed unprocurable from a majority of admitted insurers, and therefore eligible for placing with nonadmitted insurers, if the proposed form of contract cannot lawfully be issued by an admitted insurer.

§ 2135. Not Unprocurable If Combination of Classes Not Authorized.

The refusal of admitted insurers to write a form of contract is not a basis for the contention that such insurance is not procurable from a majority of admitted insurers, if the form of contract involves a combination of classes of insurance which cannot lawfully be combined in a single certificate of authority to one admitted insurer. In such case separate forms of contract, each incorporating a class or a lawful combination of classes, must be offered to and refused by a majority of insurers admitted for each such class or combination of classes, before such insurance can be placed with nonadmitted insurers.

§ 2136. Artificial Division of Coverage Prohibited.

Artificial divisions of coverage in one class or in any form of coverage under one class, into two or more proposed contracts, for the purpose of rendering a portion of the coverage unacceptable to a majority of insurers admitted for that class, or for the purpose of obtaining a rate advantage upon the entire risk, is prohibited where the entire coverage sought in that class or form would be acceptable as a single contract to such 'majority of admitted insurers.

§ 2137. Refusal by Admitted Insurers to Write Lawful Coverage by Mutual Agreement.

The refusal of a majority of admitted insurers to write a lawful form of coverage offered them, solely upon the basis of mutual agreement so not to write, where such form of coverage can be demonstrated to be proper and necessary to the protection of the citizen (and not prohibited by law), will permit the surplus line broker to write such coverage in nonadmitted insurers upon such refusal. A test of good faith of the surplus line broker in each such transaction will be a comparison of the rate or premium involved. Compliance with filing requirements of Section 1763 of the Insurance Code will be enforced.

§ 2138. Rejection of Part of Class by Admitted Insurers.

Where one portion of insurance in one class is acceptable to admitted insurers, but another portion in the same class is not acceptable, then if it can be shown that nonadmitted insurers will accept the entire coverage but not the rejected portion alone, the entire coverage in that class may be placed with nonadmitted insurers after approval by the commissioner.

RATES FOR COVERAGE

§ 2139. Offered at Specified Rate: Filing with Commissioner.

No form of coverage offered to admitted insurers upon the basis of a specified rate or premium will be considered eligible for nonadmitted writing, unless filed with the commissioner, subject to the provisions of Section 1763 of the Insurance Code.

§ 2140. Use of Broker's License for Rate Competition.

The use of a surplus line broker's license for the sole purpose of premium or rate competition with admitted insurers is prohibited. The commissioner is of the opinion, however, that the act does not contemplate the forcing by admitted insurers of unreasonable or arbitrary rates upon the insuring public.

RULES COVERING SPECIFIC POLICY FORMS HERETOFORE SUBMITTED TO THE COMMISSIONER

§ 2141. Life Insurance.

(Ins. C. 101.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

§ 2142. Fire Insurance.

(Ins. C. 102.) Attention is directed to the law prohibiting the use of any form other than the California Standard Form Fire Insurance Policy. (Ins. C. 2070.) This applies to both primary and excess fire insurance.

§ 2143. Earthquake Insurance.

First loss (primary) earthquake insurance may be procured from nonadmitted insurers. If at least one of the following elements is present, such insurance may be procured from such insurers without restriction as to rates:

(a) The deductible is at least 25 percent less than the following:

(1) For dwellings of Class D (one to four dwellings) Construction (including farm dwellings) and the contents thereof.

One–half of 1 percent of the value of the property insured or $250, whichever is the higher.

(2) For all other buildings of Class I to VI Construction (wood frame, stucco, steel frame or steel and re–enforced concrete) and the contents thereof

One–half of 1 percent of the value of the property insured or $1,000, whichever is the higher

(3) For buildings of Classes VIIa and VIIb (ordinary brick building not re–enforced) Construction and the contents thereof

2 percent of the value of the property insured or $2,000, whichever is the higher

(4) For buildings of Classes VIIIa and VIIIb (hollow tile or hollow concrete block) Construction and the contents thereof

5 percent of the value of the property insured or $3,000, whichever is the higher.

(b) The average or co–insurance clause is not required, or if required, requires insurance in an amount equal to a percentage of the value of the following percent value of property insured which is less than the following percentages thereof:

(1) Construction Classes I to VI 3%
(2) Construction Classes VIIa and VIIb. 6%
(3) Construction Classes VIIIa and VIIIb 9%

(c) The policy covers two or more subjects of insurance and does not include a distribution clause.

(d) The placement of the coverage is not contingent upon the placing of fire insurance covering the same property.

If at least one of the above elements is not present, then the procuring of such insurance from nonadmitted insurers must be in conformity with the general rules and basic principles as set forth in this article.

NOTE: Authority cited: Section 1763, Insurance Code.

HISTORY

1. Amendment filed 10–13–54; designated effective 11–15–54 (Register 54, No. 22).

§ 2144. Riot, Strike, Civil Commotion and Malicious Damage.

The noncancellable feature of policies of this form constitutes a material advantage to the insured not now procurable from admitted insurers. Such noncancellable insurance, but not cancellable insurance, is therefore exempt until further notice from the submission rules.

§ 2145. Depreciation Insurance.

Until admitted insurers provide a market for depreciation insurance, such insurance may be procured from nonadmitted insurers, exempt until further notice from the submission rules. Coverage offered must not in any way encroach upon primary fire insurance.

§ 2146. Collapse Insurance.

Until admitted insurers provide a market for collapse insurance, such insurance may be procured from nonadmitted insurers, exempt until further notice from the submission rules. Coverage submitted or written must specifically exclude all loss or damage arising from earthquake or fire. Earthquake or fire insurance may be placed with nonadmitted insurers only under the rules applicable to each.

Marine Insurance. (Ins. C. 103.) (Classification includes inland marine insurance.)

§ 2147. (a) Furriers Block Policy.

This form has been submitted for a ruling as to whether or not same is permissible for nonadmitted insurers. The request for ruling is based upon a form similar to the Jewelers Block Form but covering furs, namely covering not only merchandise in stock at the assured's permanent location or locations, but outside risk of the insured against fire arid supplementary lines, burglary and other hazards. Unlike the Jewelers Block Form Section 103 of the Insurance Code does not authorize issuance of such policies covering furs as marine insurance.

Forms in nonadmitted insurers covering all hazards of the Furriers Block Policy but specifically excepting fire and supplemental coverages attaching to assured's merchandise at assured's permanent location or locations are permissible for writing in nonadmitted insurers subject to the submission rules.

It will be understood that the rates applying to the several burglary coverages of the Block policy will be not less than those quoted by admitted insurers.

§ 2148. Negative Film Floater.

This form may be placed with nonadmitted insurers subject to the general rules and basic principles. Present forms submitted to the Commissioner as being those in use by nonadmitted insurers do not, in my opinion, offer substantial difference in coverage.

§ 2149. Other Forms of Inland Marine.

All other forms of Inland Marine Insurance must be submitted in conformity with the general rules and basic principles.

§ 2150. Title Insurance.

(Ins. C. 104.) No forms of policies having been submitted, the writing of non–admitted insurance must be in conformity with the general rules and basic principles.

§ 2151. Surety Insurance.

(Ins. C. 105.) (Attention is directed to the Code definition which includes Fidelity Insurance and Bankers, Brokers and Commercial Blanket Bonds.)

No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic

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principles. Compliance with filing requirements of Section 1763 of the Insurance Code will be enforced.

§ 2152. Disability.

(Ins. C. 106.) No forms have been submitted, but it has been brought to the notice of the Commissioner that risks involving "special hazards" can not be placed in admitted markets. All risks involving "special hazards" may be placed with nonadmitted insurers subject to the general rules and basic principles.

§ 2153. Plate Glass.

(Ins. C. 107.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

§ 2154. Liability.

(Ins. C. 108.) (It should be noted that the code definition of Liability Insurance includes "insurance against loss resulting from liability for damage to property or property interests of others, but does not include workmen's compensation, common carrier liability, boiler and machinery or team and vehicle insurance.")

§ 2155.

The question has been submitted as to the propriety of dividing liability lines into:

(a) (1) Primary coverage and

(2) Excess coverage for submission purposes, and the Commissioner has been asked to rule whether such division would be considered a violation of the artificial division rule.

(b) Unless the excess coverage upon any risk is written in nonadmitted insurers at a rate or premium comparable with that regularly chargeable for the excess portion by the primary carrier on such risk, the division of such risk into primary and excess will be considered a violation of the artificial division rule, subject to the following exceptions:

(1) Excess insurance written by nonadmitted insurers in excess of a net retention of risk by the assured.

(2) Excess insurance written by nonadmitted insurers because of a refusal in writing by the primary admitted insurer to assume the limits of liability desired by the assured.

(3) Excess insurance written by nonadmitted insurers because of a written demand by the assured that the entire liability be not placed with one insurer, such request to set forth specifically the assured's reason therefor.*

§ 2156.

All excess insurance shall be subject to the general rules and basic principles, and is available for nonadmitted insurers only upon a majority refusal by admitted insurers.*

§ 2157.

Special situations arising in connection with coverages such as Hospital Malpractice Liability and Hospital Liability for the same risk will be governed by Section 2138.*

§ 2158. Workmen's Compensation.

(Ins. C. 109.) By virtue of the Attorney General's opinion under date of July 26, 1948, the writing of excess aggregate (stop loss) and excess catastrophe (straight excess) was declared to be subject to the minimum rating law (Ins. C. 11730 to 11742), and the policy approval law. (Ins. C. 11650 to 11662)*

§ 2159. Common Carrier Liability.

(Ins. C. 110.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

(a) Questions of

(1) Primary coverage and

(2) Excess coverage are subject to the same rules and regulations as defined under Liability, Section 2155.

(b) Reference is made to Section 1760.5 of the Insurance Code, subparagraphs (b), (c) and (d) which remove from the operations of the Act, insurance for certain common carriers such as steamships, railroads and aircraft (other than public liability hazards).*

§ 2160. Boiler and Machinery.

(Ins. C. 111.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles. Questions of

(a) Primary coverage and

(b) Excess coverage

are subject to the same rules and regulations as defined under Liability, Section 2155.*

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*For statutory and source citation, see note to §2131.

§ 2161. Burglary.

(Ins. C. 112.) "Form G" burglary policy issued by Lloyds, London, has been submitted. The questions raised are under two heads: (1) rate and co–insurance; (2) extension of coverage to premises" instead of "within the residence" as appearing in forms of admitted insurers, and to personal effects in hotels.

(a) As to question (1), rate and co–insurance: Until admitted insurers recognize the apparent reasonableness of a substantial reduction in rate per unit of coverage upon application of the 100% co–insurance clause, it is hereby ruled that refusal of a majority of admitted insurers to accept upon the basis of 100% co–insurance, with reasonable rate allowance therefor, may be considered a refusal to write, and permits the surplus line broker to place coverage with a nonadmitted insurer.

(b) As to question (2) extension of coverage to "premises" instead of "within the residence," it is ruled that the insured is entitled to procure coverage on property located on the "premises" and if such coverage is not procurable from a majority of admitted insurers, an offering upon the basis of inclusion of such coverage win be considered sufficient to comply with the submission rules. As to coverage in hotels or away from the premises, this ruling will not apply; inasmuch as a majority of admitted insurers are writing tourist floater or traveller's policies.

§ 2162. Same: Other Forms.

All other forms of burglary insurance must be written in conformity with the general rules and basic principles.

§ 2163. Credit Insurance.

(Ins. C. 113.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

§ 2164. Sprinkler.

(Ins. C. 114.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

§ 2165. Team and Vehicle.

(Ins. C. 115.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic regulations. Questions of (a) primary coverage and (b) excess coverage are subject to the same rules and regulations as defined under Liability, Section 2155.

§ 2166. Automobile.

(Ins. C. 116.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles. Questions of (a) primary coverage and (b) excess coverage are subject to the same rules and regulations as defined under Liability, Section 2155.

§ 2167. Mortgage Insurance.

(Ins. C. 117.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

§ 2168. Aircraft Insurance.

(Ins. C. 118.) Excluded operation under the Act.

The Code definition of aircraft insurance specifically excludes insurance against "loss resulting from accident or physical injury, fatal or non-fatal, to any natural person."

§ 2169. Land Value.

(Ins. C. 119.) This section of the Insurance Code repealed and Land Value insurance prohibited.

§ 2170. Miscellaneous.

(Ins. C. 120.) No forms of policies having been submitted, the writing of nonadmitted insurance must be in conformity with the general rules and basic principles.

§ 2171. Third Party Property Damage Insurance.

This rule refers to that form of coverage which is not necessarily confined to one class of insurance but deals with hazards under the general heading of third party property damage.

Recognizing the restrictions of the present market, it is suggested that such amount of such insurance as can readily be placed with admitted insurers be offered to such admitted insurers.

§ 2171.1. Notice to Insureds.

On and after October 1, 1972, every certificate, policy, contract, cover note, or other evidence of insurance delivered or issued for delivery in California by a Surplus Line Broker shall contain prominently displayed on the face page thereof by means of a sticker, an imprint, or in some other manner the following statement:

> This insurance is issued pursuant to the California Insurance Code, Sections 1760 through 1780, and is placed in an insurer or insurers not holding a Certificate of Authority from or regulated by the California Insurance Commissioner.

On or before October 1, 1972, every Surplus Line Broker licensed by the Insurance Commissioner to transact surplus line insurance business in California shall report to the office of The Surplus Line Association its selected manner of compliance with the above-required notice.

NOTE: Authority cited: Section 1763, Insurance Code.

HISTORY

1. New section filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

§ 2172. Filing Rules.

(a) On and after December 1, 1938, the Insurance Commissioner will excuse all surplus line risks from the filing requirement if the same are filed with the Stamping Office of the Surplus Line Association, with the exception of those risks filed with him through the Stamping Office.

(b) Any surplus line broker making a filing with the Stamping Office is thereby deemed to constitute the Stamping Office his agent to make such filing with the Commissioner in its discretion.

(c) The Commissioner reserves the power to examine and review any and all such filings with the Stamping Office and all filings therewith are subject to the exercise of this power. (Ins. C. 1763.)

§ 2173. Pre-Condition to Placement with Nonadmitted Insurers.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Section 1763, Insurance Code.

HISTORY

1. New section filed 11–16–90 as an emergency; operative 11–16–90 (Register 90, No. 50). A Certificate of Compliance must be transmitted to OAL by 3–18–91 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3–18–91 as an emergency; operative 3–18–91 (Register 91, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–16–91 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 96, No. 16).
4. Certificate of Compliance as to 3–18–91 order transmitted to OAL 7–10–91; disapproved by OAL on 8–6 –91 and repeal ordered 8–12–91 (Register 96, No. 16).

§ 2174. Placement of Insurance with Alien Nonadmitted Insurers.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code

HISTORY

1. New section filed 12–28–90 as an emergency; operative 1–27–91 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 5–28–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 41).
3. New section filed 7–1–91 as an emergency; operative 7–1–91 (Register 91, No. 41). A Certificate of Compliance must be transmitted to OAL by 10–29–91 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction moving forms after section 2174.14 (Register 92, No. 32).
5. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2174.1. Definitions.

(a) "Filing" means the providing of documents required under Insurance Code Section 1765.1(c), (d) and (i) to the Department.

(b) "Report of Examination" means a report of examination by the insurer's domiciliary regulator listing the condition of the insurer at an as of date that is no later than 5 years from the date of submission.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer of former section 2174.1 and renumbering and amendment of former section 2174.2 to section 2174.1 filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.2. Schedule of Fees.

(a) Initial Filing

Insurer, or licensee, shall pay in support of a filing for qualification as an eligible surplus lines insurer pursuant to Insurance Code Section 1765.1 the filing fee of $4500 except that for a group of incorporated or a combination of incorporated and unincorporated insurers which underwrite insurance as members of a group of syndicates pursuant to Insurance Code Section 1765.1(a)(2)(C), the filing fee shall be $4500. In addition, the group shall reimburse the Department for the costs of review of any individual syndicate.

(b) Annual Renewal

Within twelve months after being added to the list of approved surplus line carriers and annually thereafter, a filing of all the documents required by 2174.3(a) must be made and the filing fee for that annual renewal will be $2250 except that for a group of incorporated or a combination of incorporated insurers and unincorporated insurers which underwrite insurance as members of a group of syndicates pursuant to Insurance Code Section 1765.1(a)(2)(C), the filing fee shall be $2250. In addition, the group shall reimburse the Department for the costs of review of any individual syndicate.

(c) Periodic Updates

Upon the filing of documents, pursuant to the update provisions of 2174.3(b) throughout the year, the filing fee will be $250 per document for updates of financial documents; and $35 per document for all other updates. These document fees shall not apply to any documents filed in connection with the review of any syndicate that is part of a group of incorporated or a combination of incorporated insurers and unincorporated insurers which underwrite insurance as members of a group of syndicates pursuant to Insurance Code Section 1765.1(a)(2)(C).

(d) Additional Requirements

All filings made pursuant to this section shall meet the requirements of Insurance Code Section 8 and shall be forwarded to the Department at the following address:

SURPLUS LINES ENFORCEMENT UNIT
INVESTIGATION BUREAU
CALIFORNIA DEPARTMENT OF INSURANCE
45 FREMONT
SAN FRANCISCO, CA 94105

All filings shall be made in quadruplicate, unless otherwise agreed to by the Department.

NOTE: Authority cited: Sections 1763 and 1771, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order including amendment of subsections (f) and (j) transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Renumbering of former section 2174.2 to section 2174.1, new section 2174.2(a)–(c), and relocation and amendment of former section 2174.4(d) to section 2174.2(d) filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.3. Documents to Submit.

(a) Annual Renewal Filing

Within a year of the initial filing and every year thereafter the insurer or the licensee must file the following:

(1) Foreign Insurers

(A) Financial Documents

(i) Annual Statement as required by Insurance Code Section 1765.1(c)(1)(A)

(ii) Audited Financial Report as required by Insurance Code Section 1765.1(c)(1)(B) & (D)

(iii) Latest Report of Examination as required by Insurance Code Section 1765.1(c)(7)

(iv) Quarterly Financial Statements

(B) Non–financial Documents

(i) Certified License as required by Insurance Code Section 1765.1(c)(2)

(ii) Certificate of Good Standing as required by Insurance Code 1765.1 Section (c)(2)

(iii) Agent for Service of Process as required by Insurance Code Section 1765.1(c)(3)

(iv) Principal Place of Business as required by Insurance Code Section 1765.1(c)(4)

(v) Market Conduct Statement as required by Insurance Code Section 1765.1(c)(5)

(vi) Regulatory Disclosure Statement as required by Insurance Code Section 1765.1(c)(6)

(vii) List of Surplus Line Brokers authorized to issue policies as required by Insurance Code Section 1765.1(c)(7)

(C) Supplemental information

(i) Proposed Plan of Operation as required under Insurance Code 1765.1(d)(1) and (h)

(ii) Biographical Affidavits pursuant to Insurance Code Section 1765.(d)(1)

(2) Alien Insurers

(A) Financial Documents

(i) Audited Financial Report as required by Insurance Code Section 1765.1(c)(1)(B) & (E)

(ii) Latest Financial Statement as required by Insurance Code Section 1765.1(c)(1)(A) & (E)

(iii) Quarterly or half–yearly if available

(B) Non–financial Documents

(i) Trust Agreement as required by Insurance Code Section 1765.1(c)(1)(C)(i)

(ii) Certified License as required by Insurance Code 1765.1(c)(2)

(iii) Certificate of Good Standing as required by Insurance Code Section 1765.1(c)(2)

(iv) Agent for Service of Process as required by Insurance Code Section 1765.1(c)(3)

(v) Principal Place of Business as required by Insurance Code Section 1765.1(c)(4)

(vi) Market Conduct Statement as required by Insurance Code Section 1765.1(c)(5)

(vii) Regulatory Disclosure Statement as required by Insurance Code Section 1765.1(c)(6)

(viii) List of Authorized Surplus Line Brokers as required by Insurance Code Section 1765.1(c)(7)

(ix) Most recent quarterly statement of account of assets in the trust as required by Insurance Code Section 1765.1(c)(1)(C)(ii)

(C) Supplemental Information

(i) Proposed Plan of Operation as required by Insurance Code Section 1765.1(d)(1) and (h)

(ii) Biographical Affidavits pursuant to Insurance Code Section 1765.1(d)(1)

All documents and information required to be filed pursuant to subdivision (a) must be the most recent version of the document or information. If a document or information has previously been filed to the Department it need not be refiled as part of the annual renewal filing. The cover letter with the annual renewal should mention when and what document was previously filed. If one or more of the documents listed in subdivision (a) is not filed with the Department as part of the annual renewal filing then explain in writing what those documents are and the reason they are not being filed.

(b) Update Requirements

Whenever a document required in the initial filing or annual renewal filing is materially changed or a more recent version becomes available, the insurer or the licensee must file the document as soon as it is available.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer and new section filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.4. Public Availability of Documents.

(a) All documents filed with the Commissioner under Insurance Code Section 1765.1 except the biographical affidavits and the plan of operation, all periodic filings required under the trust agreement, all order issued under Insurance Code Section 1765.1, and all evidence, pleadings and documents relating to hearings held under Insurance Code Section 1765.1, shall be available for public review. Nothing herein shall make any memorandum, study or other document prepared by or for the Department staff in its official capacity, for internal Department use, a public document.

(b) The Commissioner may prepare and distribute to the public a list of insurers to whom section 1765.1 orders have been issued.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 856(a), 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order including amendment of subsection (a) and NOTE transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Editorial correction of printing error in subsections (c)(3) and (c)(4) (Register 93, No. 24).
4. Repealer of subsections (a)–(c)(4), relocation of former section 2174.4(d) to section 2174.2(d), and renumbering and amendment of former section 2174.11 to section 2174.4 filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.5. Documents to Submit.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.6. Filing.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.7. Rejection of Documents.

NOTE: Authority cited: Sections 1763 and 12977, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.8. List of Filings.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.9. Standards For Evaluation Of Insurers.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763, 1765 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order including amendment of subsection (a)(4) transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.10. Procedures For Orders Under Section 1765.1.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.11. Public Availability of Documents.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 856(a), 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Renumbering of former section 2174.11 to section 2174.4 filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.12. Status of Nonadmitted Insurers.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763, 1765, 1765.1 and 1776, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order including amendment of section transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.13. Transition.

NOTE: Authority cited: Section 1763, Insurance Code. Reference: Sections 1763 and 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–12–92 order including amendment of section transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
3. Repealer filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

§ 2174.14. Notice to Licensees.

NOTE: Authority cited: Section 1763 and 1765.1, Insurance Code. Reference: Section 1765.1, Insurance Code.

HISTORY

1. New section filed 6–12–92 as an emergency; operative 6–12–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–12–92 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction adding Appendices C and D (Register 92, No. 30).
3. Certificate of Compliance as to 6–12–92 order transmitted to OAL 10–13–92 and filed 11–25–92 (Register 92, No. 48).
4. Repealer of section and appendices A–D filed 2–24–99; operative 2–24–99 pursuant to Government Code section 11343.4(d) (Register 99, No. 9).

Article 4.5. Procedures Governing Persons Subject to Title 18 United States Code Section 1033

§ 2175. Procedures Governing Prohibited Persons.

HISTORY

1. New article 4.5 (sections 2175–2177.14) filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2175.1. Purpose.

The purpose of these regulations is to implement the provisions of Title 18 United States Code sections 1033 "(the Act"), as well as California Insurance Code sections 1723 and 1742.2.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2175.2. Definitions.

For the purpose of these regulations, the following definitions shall apply:

(a) "Application" shall mean any filing made with the California Department of Insurance (Department) for written consent to engage in the business of insurance.

(b) "Applicant" shall mean any person subject to the provisions of Title 18 United States Code §1033 , who files an application for written consent to engage in the business of insurance.

(c) "Breach of Trust" refers to certain crimes or offenses, including, but not limited to, any offense constituting or involving misuse, misapplication or misappropriation of (1) anything of value held as a fiduciary (including, but not limited to, a trustee, administrator, executor, conservator, receiver, guardian, agent, employee, partner, officer, director or public servant) or (2) anything of value of any public, private or charitable entity.

(d) "Burden of Proof" means the necessity or duty of proving a fact that is in dispute on an issue raised at a hearing on a Request for Written Consent.

(e) "Business of Insurance" means: (1) the writing of insurance, or (2) the reinsuring of risks, by an insurer, including all acts necessary or incidental to such writing or reinsurance and the activities of persons who act as, or are, officers, directors, agents, or employees of insurers or who are other persons authorized to act on behalf of such persons.

(f) "Conviction" means a finding of guilty or a plea of guilty, nolo contendere or no contest in a criminal court of the United States of America or in any state, commonwealth or possession. Completion of deferred adjudication and conditional discharges are not convictions.

(g) "Dishonesty" refers to a crime or offense which includes, but is not limited to, any offense constituting or involving perjury, bribery, forgery, counterfeiting, false or misleading oral or written statements, deception, fraud, schemes or artifices to deceive or defraud, material misrepresentations and the failure to disclose material facts.

(h) "Felony" means

(1) Any Federal crime for which the maximum authorized punishment exceeds one year of imprisonment;

(2) Any crime for which the maximum authorized punishment exceeds one year incarceration; or

(3) Any crime in any other state, commonwealth, territory or possession that is identified as a felony in that state, commonwealth, territory or possession, or if not identified as a felony in said other jurisdiction, any offense for which the maximum authorized punishment exceeds one year incarceration.

(4) Any conviction of a felony crime of dishonesty, breach of trust or violation of 18 U.S.C. § 1033 which has been set aside pursuant to California Penal Code section 1203.4.

(i) "Insurer" means any entity that transacts the business of insurance or that reinsures risks, and includes any person who acts as, is, an officer, director, agent or employee of that business.

(j) "Interstate Commerce," means the following:

(1) Commerce within the District of Columbia, or any territory, or possession of the United States;

(2) All commerce between any point in the State, territory, possession, or the District of Columbia and any point outside thereof;

(3) All commerce between points within the same State through any place outside such State via the Internet or any other means to receive commerce; or

(4) All other commerce over which the United States has Jurisdiction.

(k) "License" means any license, registration, certificate of authority or other permit or approval issued or granted by the Commissioner of Insurance.

(*l*) "Licensee" means any person or entity holding a license.

(m) "Prohibited Person" means any person who has been convicted of felony crimes of dishonesty, breach of trust in a state or federal jurisdiction or who has been convicted of any violation of 18 U.S.C. §1033 (the "Act"), who wishes to engage in or transact the business of insurance in this State, or who wishes to engage in or transact the business of insurance for insurers, and/or reinsurers and/or their agents and employees who are domiciled in this State. A "Prohibited Person" may be an officer, director or employee of an insurance agency or an insurance company, an agent, solicitor, broker, consultant, third-party administrator, managing general agent, or subcontractor representing an insurance agency or insurance company who engages in or transacts the business of insurance.

(n) "Request for Consent" means a completed application, submitted by a Prohibited Person that requests the Commissioner's express, written consent to allow that Prohibited Person to engage in or transact, or to continue to engage in or transact, the business of Insurance.

(o) "State" for the purposes of this regulation, includes any State in the United States the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa and the Trust Territory of the Pacific Islands.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3-10-2003; operative 4-9-2003 (Register 2003, No. 11).

§ 2175.3. Who Must Comply.

Any and all Prohibited Persons who are currently transacting, or engaging in, the business of insurance, or who intend to transact, or engage in, the business of insurance, must submit a completed Request for Consent to the California Department of Insurance (Department).

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3-10-2003; operative 4-9-2003 (Register 2003, No. 11).

§ 2175.4. Prohibited Persons Currently Engaged in or Transacting the Business of Insurance.

(a) There are no provisions in the Act or these regulations that exempt or except any Prohibited Person, who is currently engaging in, or transacting, the business of insurance from compliance with the Act and these regulations. The Act and these regulations expressly apply to all persons currently licensed who have been convicted of any criminal felony involving dishonesty, breach of trust or any violation of the Act.

(b) Any and all currently licensed individuals who are subject to the Act and who were granted a license by the Department following full and complete disclosure of their criminal history shall be deemed to have the Insurance Commissioner's temporary consent to engage in or transact the business of insurance within the scope of their license authority only if the currently licensed individual submits an application for written consent within ninety (90) days from the effective date of these regulations. Any current licensee who is a Prohibited Person and who fails to submit an application for Written Consent within the ninety (90) day period will be barred from transacting the business of insurance as set forth in Title 18 USC section 1033.

(c) Any and all Prohibited Persons engaging in, or transacting, the business of insurance, without the express Written Consent of the Commissioner, are in violation of the Act and risk federal criminal sanctions.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3-10-2003; operative 4-9-2003 (Register 2003, No. 11).

§ 2175.5. Responsibility of Insurers and Other Employers to Identify Prohibited Persons.

(a) It is the responsibility of insurers and of any other employer engaging in, or transacting the business of insurance to make a diligent effort to identify Prohibited Persons and to ensure that Prohibited Persons are not engaging in, or transacting, the business of insurance in violation of the Act and of these regulations. Insurers and other employers must actively seek to determine whether or not Prohibited Persons are in their employ and are engaging in or transacting the business of insurance.

(b) The existence of a valid license for a Prohibited Person does not waive, excuse, except or exempt an insurer or other employer from its responsibility under subdivision (a) nor the insurer's or other employer's ultimate responsibility for compliance with the provisions of the Act and these regulations.

(c) An insurer or employer must notify the Department of Insurance, in writing, of any Prohibited Person who is engaged in the business of insurance without Written Consent.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2175.6. Applications for Written Consent.

The Prohibited Person must file an Application for Written Consent with the Department as set forth herein.

(a) Prohibited Persons must submit to the Department an Application for Written Consent (National Association of Insurance Commissioners' (NAIC) Short Form Application for Written Consent to Engage in the Business of Insurance Pursuant to 18 U.S.C. § 1033 and 1034 (dated 1998), which is incorporated herein by this reference). Prohibited Persons are those defined in section 2175.2(m), herein.

(b) It is the responsibility of the applicant to read the Application in its entirety. Every question must be answered completely and truthfully. The NAIC Short Form Application is available at the Department's website at www.insurance.ca.gov and at the Department of Insurance Licensing Background Bureau.

(c) Failure to submit a complete Application may result in delay or denial of the Commissioner's Written Consent. The purpose of the Application is to provide the Prohibited Person with an opportunity to demonstrate that, notwithstanding the provisions of the Act, the Prohibited Person is fit to transact, or to engage in, the business of insurance without risk to consumers or insurers.

(d) The burden is upon the Prohibited Person to establish that the Commissioner's Written Consent should be granted.

(e) All Applications submitted to the Department must be typewritten. Any application that is not typewritten will be returned to the Applicant.

(f) All Applications submitted must be complete. Certified copies of all court documents setting forth the initial conviction and any subsequent disposition, together with any other relevant documents or information that the Prohibited Person would like to have considered must be submitted within thirty (30) days of the Department's receipt of the application.

(g) Fingerprint impressions on FBI Form #FD–258 (Rev. 12–29–1982, which is incorporated herein by this reference) should be submitted directly to "Sylvan/Identix Fingerprinting Centers", along with a check in the amount of $74.00 made payable to "Sylvan/Identix Fingerprinting Centers." Fingerprint card completion instructions are available on the Department's website at www.insurance.ca.gov.

An application is incomplete without the following:

(1) An application processing fee in the amount of $124.00, payable to the California Department of Insurance.

(2) Two 2″ by 2″ recent passport photographs attached to the upper right hand corner of the first page of the application for written consent.

(3) Any amendment to the application must be filed immediately upon the occurrence of any event that would change any answer on the application. Failure to file a timely amendment may result in denial of the Request for Written Consent or the immediate withdrawal of previously granted consent.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C § 1033.

HISTORY

1. New section filed 8–21–2003; operative 8–21–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 34).

§ 2175.7. Consideration of Applications for Written Consent.

(a) The Insurance Commissioner shall have the sole discretion to grant or deny any Application for Written Consent to engage in or transact the business of insurance.

(b) Factors to be considered in granting or denying an Application for Written Consent will include, but are not limited to:

(1) The nature and severity of the crime.

(2) The length of time since the conviction.

(3) The injury and/or loss caused by the Prohibited Person. Whether the conviction is related to the business of insurance.

(4) Whether the Prohibited Person received a pardon from the sovereign that convicted him.

(5) Whether the Prohibited Person completed parole or probation.

(6) Whether a breach of trust, dishonesty or a violation of the Act was involved.

(7) The nature and strength of character reference letters.

(8) The person's business and personal record before and after the conviction.

(9) Whether and to what extent the person has made material false statements in an application, renewal or in other documents filed with the Commissioner.

(10) Whether and to what extent the person has made material false statements in applications or other documents filed with other State or federal agencies.

(11) Whether the Prohibited Person's conviction was expunged.

(12) Whether the conviction was received in a foreign country.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1699(a)–(d), 1723(a) and (b) and 1742.2, Insurance Code.

HISTORY

1. New section filed 8–21–2003; operative 8–21–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 34).

§ 2175.8. Written Consent as a Prerequisite for Obtaining or Retaining a License.

(a) Prohibited Persons are required to obtain the express, written consent of the Commissioner before any license application shall be considered.

(b) Licensees, who are prohibited persons, must have the Commissioner's express Written Consent pursuant to the Act and these regulations prior to engaging in, or transacting, the business of insurance. Licensees who have complied with the provisions of section 2175.4 herein and who are within the ninety (90) day period specified in section 2175.4 are not subject to this provision.

(c) No Prohibited Person shall be granted a license, shall be permitted to retain a license or shall engage in, or transact, the business of insurance if their Request for Written Consent has been denied.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. § 1033.

HISTORY

1. New section filed 8–21–2003; operative 8–21–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 34).

§ 2175.9. Standard Form of Application for Requesting Written Consent.

(a) Prohibited Persons seeking the Commissioner's Written Consent will use the NAIC Short Form Application For Written Consent to Engage in the Business of Insurance Pursuant to 18 U.S.C. § 1033 and 1034 for the use of Prohibited Persons (dated 1998), which is incorporated herein by this reference. The Prohibited Person seeking Written Consent must sign the Application.

(b) The Commissioner may request additional information at any time from an Applicant to support a pending Application for Written Consent. The Applicant is required to support a pending Application by promptly providing any requested information. Failure to provide such information may result in the Commissioner's denial of the Application.

(c) If consent is denied, the Applicant and the employer identified in the application will be notified in writing of the basis for that denial. The Notice of Denial will provide the Applicant with a denial statement as well as a time line and instruction for any appeal of the denial.

(d) Upon approval, the Commissioner will provide documentation of Written Consent containing the terms and conditions upon which the consent has been granted. Failure to comply with all terms and conditions of consent will result in the immediate termination of consent and summary revocation of license to transact the business of insurance. Terms and conditions of consent may include, but are not limited, to the following:

Any subsequent misdemeanor or felony charge involving dishonesty, breach of trust or violation of 18 U.S.C. § 1033 against a Prohibited Person;

Failure to notify the Department of any misdemeanor or felony charge involving dishonesty, breach of trust or violation of 18 U.S.C. § 1033 against a Prohibited Person;

The filing of an Administrative sanction against a Prohibited Person;

Failure to comply with any provision of these regulations;

Failure to notify the Department upon the filing of any action against a Prohibited Person by a regulator;

Failure to amend an application for Written Consent upon a change in job duties;

Failure to notify employer of status as a Prohibited Person.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1669, 1723, 1727 and 1742.2, Insurance Code.

HISTORY

1. New section filed 8–21–2003; operative 8–21–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 34).

§ 2175.10. Requirements for Character References.

Character references may be submitted to the Department for the Commissioner's consideration. Character references shall state how long and in what capacity the person making the reference has known the applicant. References shall also expressly state that the person providing the reference is aware that the reference is being provided in connection with a Request for Written Consent to engage in or transact the business of insurance despite the existence of a relevant felony criminal conviction.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1723, 1727 and 1742.2, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).
2. Editorial correction adding HISTORY 1 (Register 2003, No. 34).

§ 2176. Denial, Expiration or Termination of Written Consent.

§ 2176.1. Effect of False or Misleading Statements.

(a) Any Written Consent granted by the Commissioner shall be conditioned upon the truth and veracity of the documents and information submitted by or on behalf of the Prohibited Person making the Request for Written Consent. In the event that the Department determines that the Prohibited Person receiving the Written Consent, or their representative, has made materially false or misleading statements, or has failed to disclose material information, the Written Consent shall be void ab initio.

(b) If the Department determines that a Prohibited Person has violated the terms of Written Consent in any way, the consent shall terminate immediately.

(c) Knowingly and willfully providing false information to the Department for any purpose constitutes a violation of the Act and is grounds for immediate, summary revocation of any license issued by the Department.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2176.2. Written Consent Effective for Specified Positions and Responsibilities Only.

Any Written Consent issued by the Commissioner shall be for the Prohibited Person remaining in the same or similar job position with the same responsibilities as attested to in the initial Request for Written Consent. The Written Consent will contain a reference to Title 18 U.S.C. 1033(e)(1)(B)(2). A change in job responsibilities requires the Prohibited Person to file an amended Request for Written Consent. Failure to amend an application for Written Consent upon any change in job responsibilities will result in immediate termination of Written Consent.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2176.3. Temporary Written Consent.

(a) The Commissioner has the discretion to grant a temporary Written Consent that will expire at a time certain.

(b) Upon the expiration of a temporary Written Consent, the Prohibited Person is in violation of the Act if the Prohibited Person is engaging in or transacting the business of insurance without first receiving a new, express, Written Consent from the Commissioner.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1065.3, 1669 and 1742.2, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2176.4. Subsequent Convictions of Prohibited Persons Previously Granted Written Consent.

Any Prohibited Person given a Written Consent to participate in the business of insurance shall immediately notify the Department if the Prohibited Person is subsequently convicted of an offense under 18 U.S.C. §1033, or any felony offense involving dishonesty or breach of trust making them once again subject to the provisions of 18 U.S.C. §1033 and these regulations. The consent previously issued is terminated automatically upon arrest or conviction for the subsequent offense. Immediately upon notification that consent has been terminated, the Prohibited Person must return the original Written Consent and all copies to the Department.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1065.3, 1669 and 1742.2, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177. Hearing Procedure.

§ 2177.1. Time Limit in Which to Request a Hearing.

Applicants who have received a Notice of Denial of Consent may request a hearing, in writing, within sixty (60) calendar days after the issue date of the Notice.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.2. Form of Request for Hearing and Information Required.

A Request for Hearing shall be in writing and must include:

(a) The name, address, telephone number, and fax number of the Prohibited Person;

(b) The name, address, telephone number, and fax number of the Prohibited Person's representative, if any;

(c) A statement explaining why the Prohibited Person should not be denied the Commissioner's Written Consent;

(d) A copy of the Commissioner's Denial of Consent;

(e) Copies of any additional documents that were not included in the Prohibited Person's initial Application, which support the Prohibited Person's explanatory statement and upon which the Prohibited Person intends to rely at the hearing.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.3. Filing and Service Requirements.

(a) An original and one copy of the Request for Hearing and all documents provided must be sent to the California Department of Insurance, Administrative Hearing Bureau, 45 Fremont Street, San Francisco, California 94105.

(b) All required documents and copies must be delivered to the Administrative Hearing Bureau either by personal delivery or U.S. Postal Service Return Receipt Requested delivery.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.4. Time of Hearing.

The Chief Administrative Law Judge of the Administrative Hearing Bureau shall assign the case to an Administrative Law Judge for hearing. An administrative law judge shall hold a hearing within sixty (60) days of the Administrative Hearing Bureau's receipt of the Department's response to the Request for Hearing. The hearing may be held on a later date upon agreement of both parties. The Administrative Law Judge shall give the parties not less than 10 days written notice of the date on which a hearing is scheduled.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.5. Continuances; Good Cause.

(a) A continuance for any act occurring under this article may be granted by the Chief Administrative Law Judge or the Administrative Law Judge for good cause shown.

(b) When seeking a continuance, a party shall apply for the continuance within five (5) business days following the time the party discovered or reasonably should have discovered the event or occurrence which establishes the good cause for the continuance. A continuance may be granted for good cause after the five (5) business days have lapsed, if the party seeking the continuance is not responsible for, or has made a good faith effort to prevent, the condition or event establishing the good cause.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.6. Role of Department of Insurance.

The Department of Insurance is a party in the hearing, representing the Commissioner. Within 20 days of notification by the Administrative Hearing Bureau of the request for hearing, the Department shall file an original and one copy of its response to the underlying issues raised by the Prohibited Person in the Request as well as an original and one copy of any documents upon which he or she plans to rely at the hearing. Copies of the Department's response and any documents filed with the Administrative Hearing Bureau shall also be served on the Prohibited Person and/or their representative, if any.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.7. Representation of Prohibited Person at the Hearing.

A Prohibited Person may be represented in the proceedings before the Administrative Hearing Bureau. A representative is not required and the representative need not be an attorney.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.8. Administrative Law Judge's Authority.

(a) Article 10 of Chapter 4.5 of the Administrative Procedure Act (commencing with Government Code section 11445.10 and concerning enforcement of subpoenas and sanctions), is adopted, and is applicable to these proceedings. The Administrative Law Judge may exercise all the authority granted pursuant to Chapter 4.5 of the Administrative Procedure Act.

(b) The Administrative Law Judge may take any other action necessary or appropriate to the discharge of his or her duties, consistent with the statutory or other authority under which the Commissioner functions. The Administrative Law Judge may issue such orders compelling the compliance of the parties and other persons subject to the jurisdiction of the Commissioner as necessary to the discharge of his or her official duties and the efficient use of the Department's judicial time and resources.

(c) The Chief Administrative Law Judge shall exercise all authority set forth in this section until a proceeding is assigned to an Administrative Law Judge.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.9. Burden of Proof.

The burden of proof at a hearing on a Request for Written Consent is on the Prohibited Person seeking the Commissioner's Written Consent to engage in or transact the business of insurance in this State.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code Reference: Sections 1723, 1727 and 1742.2, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.10. Evidence.

(a) The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of evidence over objection in civil actions.

(b) The rules of privilege shall be effective to the extent that they are otherwise required by law to be recognized at the hearing.

(c) The Administrative Law Judge has the sole discretion to exclude evidence if its probative value is substantially outweighed by the probability that its admission will necessitate undue consumption of time.

(d) No documentary evidence will be admitted into evidence at the hearing that was not previously exchanged between the parties without good cause shown why the evidence was not available to the parties for exchange prior to the hearing.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.11. Additional Evidence or Briefing.

(a) The Administrative Law Judge may require the production of further evidence or briefing on any issue. If the administrative law judge determines that specific evidence or briefing is necessary as a part of the record, he or she shall set a deadline for the parties to file the requested evidence or briefing.

(c) Unless ordered by the Administrative Law Judge, or upon written motion for good cause shown, no additional evidence shall be introduced after the close of the evidentiary hearing.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.12. Official Notice.

In reaching a decision, official notice may be taken, before submission of the case for decision, of any fact that may be judicially noticed by the courts of this state. All parties shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto. Pursuant to a written request, all parties shall be given a reasonable opportunity to refute the officially noticed matters, either by evidence or by written or oral presentation to the Administrative Law Judge.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.13. Hearing Reporter.

The proceedings at the hearing shall be reported by a hearing reporter. However, upon the consent and agreement of all parties, the proceedings may be reported electronically. Parties must make their own arrangements for payment with the hearing reporter if they wish to obtain a copy of the reporter's transcript.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2177.14. Costs.

All parties shall bear their own costs.

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; and 18 U.S.C. §1033.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003 (Register 2003, No. 11).

§ 2178. Procedures to Be Employed By the Commissioner in Considering Requests for Consent.

The following criteria shall apply to procedures employed by the Commissioner in considering Requests for Consent:

(a) Within twenty–one (21) calendar days of receipt of the application, the Commissioner shall inform the applicant, in writing, that the Application is complete. Or, if the application is deficient, the applicant will be informed, in writing, that the application is deficient and what specific information is required for completion.

(b) Any Application for Written Consent that is not resubmitted to the Department within thirty (30) days of the applicant's receipt of a Notice re deficiency of the Application, shall be deemed withdrawn.

(c) The Commissioner shall, within thirty (30) calendar days of receipt of a complete Application, reach a decision whether to grant or deny a request for consent, and shall notify the applicant of the decision. If the Commissioner has decided to deny the Application, the reason(s) therefor shall be set forth in the notification of denial.

(d) The periods set forth above shall be tolled in the event the Application requires legal action by the Commissioner.

(e) The Department of Insurance's median, minimum and maximum times for processing an Application for Written Consent, from the receipt of the initial completed Application to the final license decision (excluding Applications that require legal action by the Commissioner), are as follows:

(1) thirty (30) calendar days (median time),

(2) thirty (30) calendar days (minimum time), and

(3) forty–five (45) calendar days (maximum).

NOTE: Authority cited: Sections 1723 and 1742.2, Insurance Code. Reference: Sections 1723 and 1742.2, Insurance Code; 18 U.S.C. § 1033; and Section 15376, Government Code.

HISTORY

1. New section filed 8–21–2003; operative 8–21–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 34).

Article 5. Insurance in Connection with Sales and Loans

§ 2180. Maximum Charge; Policy Substitution.

The maximum service charge which may be made by a lender for a substitution of insurance policies pursuant to Section 771 (d) of the Insurance Code is $5.00.

NOTE: Authority cited for Article 5 (Section 2180): Section 771 (e), Insurance Code.

HISTORY

1. New Article 5 (Section 2180) filed 10–9–59; effective thirtieth day thereafter (Register 59, No. 17).

§ 2181. Purpose and Scope.

This subchapter contains rules and regulations authorized by California Insurance Code Section 771 (a).

NOTE: Authority cited: Section 771 (a), Insurance Code.

HISTORY

1. New sections 2181 and 2181.1 filed thereafter (Register 72, No. 50).

§ 2181.1. Reasonable Cause: Right to Disapprove of the Insurer Selected to Underwrite Insurance.

(a) General Provisions:

(1) Any lender engaged in the business of financing the purchase of real property or of lending money on the security of real property and any trustee, director, officer, agent or other employee, or affiliate, of any such lender shall have the right to disapprove, for reasonable cause, the insurer selected to underwrite the insurance required by the contract of sale or deed of trust or other loan agreement and shall have the right to furnish or renew such insurance if the borrower or purchaser shall have failed to furnish the insurance or renewal thereof within such reasonable time or form as may be specified in the sale or loan agreement.

(2) Notwithstanding any other provisions of these regulations, the California FAIR Plan Association shall not be rejected as an insurer.

(3) The corporate structure of an insurer shall not be a basis for disapproval of such insurer.

(4) These regulations shall not affect the respective rights of a borrower and its lender to require an insurance policy and coverage in accordance with such agreement between it and the borrower.

(5) These regulations do not apply to insurance covering personal property as the subject of security for the loan nor do they apply to insurance covering real property securing loans in excess of $75,000.

(b) "Reasonable Cause" for Disapproval. Any one or more of the following reasons may constitute reasonable cause to disapprove of the insurer selected to underwrite the insurance.

(1) Financial Status of Insurer.

(A) Failure of the insurer to be rated in the most recently published ratings made by a nationally recognized rating service.

(B) Failure of the insurer to be rated in one of the two highest policyholder ratings in the most recently published ratings made by a nationally recognized rating service.

(C) Failure of the insurer to be rated in one of the twelve highest financial ratings in the most recently published ratings made by a nationally recognized rating service.

(D) The insured amount would exceed three percent of the policyholder surplus of the insurer.

(E) Failure of the insurer to have a policyholder surplus of $5 million or more where the has already underwritten an aggregate amount of $300,000 on properties in close proximity in a tract or in adjoining tracts for the borrowers of an association.

Paragraphs (A) through (E) above shall not constitute reasonable cause to disapprove if there shall be obtained and attached to the evidence of insurance afforded to the lender appropriate evidence of reinsurance. Such reinsurance may be required by the lender to be in a company meeting all of the criteria of these regulations.

(2) License of Insurer.

Failure of the insurer or reinsurer to be licensed by the State of California to transact the line of insurance afforded.

(3) Claims Settlement Practices and Servicing Practices.

(A) Knowingly committing or performing with such frequency as to indicate a general business practice unfair claims settlement practices as defined in Section 790.03 of the Insurance Code as amended in 1972.

(B) A lender relying upon the provisions of this paragraph (3) with respect to the disapproval of a particular insurer must follow the provisions of the following subsection (d) of these regulations, which will then control the determination of this issue.

(4) Failure of the policy to stipulate on the face of the policy or the declarations page that the term of the policy shall be continuous until cancelled or nonrenewed or for no less than three years, although premium payments may be on an annual basis for a three year policy.

(5) Unwillingness of the insurer to make provision for notice of cancellation or nonrenewal to the lender in accordance with the terms of the loan agreement.

(c) As respects title insurance, reasonable cause is defined as the failure of the title insurer to:

(1) Be licensed by the State of California to transact the line of insurance afforded.

(2) Provide the insurance in conformity with all requirements of the California Insurance Code and the Regulations issued thereunder.

(3) Establish, as disclosed by its most current annual statement on file with the Insurance Commissioner of the State of California, that the amount of any loan which is to be the subject of a title insurance policy does not exceed 30% of its "surplus as regards policyholders" (see Annual Statement, Form 9, page 3, line 22). Any reinsurance or coinsurance that may be offered by the title insurer in excess of such amount shall be in such company or companies and afford such coverage as the lender shall approve.

(4) Afford the coverage required by the lender.

Notwithstanding any of the above, it is a reasonable cause for a lender to reject a policy of a title insurer if the borrower or if the seller of real property, the purchase of which is to be financed in whole or in part by the lender, is a subsidiary or affiliate (as defined in Section 1215 of the Insurance Code) of such title insurer or if such borrower or such seller is a subsidiary or affiliate of an underwritten title company (as defined in Section 12404 of the Insurance Code) that regularly makes the title searches or title examinations upon the basis of which the title insurance policy would be issued.

(d) Other "Reasonable Cause" for Disapproval. If a lender desires to reject a particular insurer on the grounds set forth in (b) (3) above or on reasonable grounds other than set forth above, the lender may submit the rejection, in writing, to the Commissioner with a copy to the insurer, agent and borrower, stating the grounds for the rejection. The insurer, agent or the borrower may contest the grounds, in writing, either on the basis of fact or on the basis of reasonableness, within fifteen days of the mailing of notice of rejection, which said mailing shall be by certified mail. If the Commissioner has not received contest of the grounds, in writing, for rejection within such fifteen days, then the rejection of the insurer shall stand as though the Commissioner had decided in favor of the lender. If the insurer, agent or borrower contests the rejection, the Commissioner shall notify the lender, the insurer, the agent and the borrower of his finding that the rejection is either upheld or denied within fifteen days of the receipt by the Commissioner of such contest of rejection.

HISTORY

1. Amendment of subsection (b) (4) filed 3–22–73 as procedural and organizational; effective upon filing (Register 73, No. 12).

Article 5.5. License Qualification Examinations

§ 2182. Limitation on Taking Further Examinations.

(a) No person who has twice failed a license qualification examination shall be permitted to take further examinations for a period of thirty (30) days from receipt of notice of said failure.

(b) No person who, after having been prohibited from taking further examinations pursuant to subsection (a) above, twice fails a license qualification examination shall be permitted to take further examinations for a period of sixty (60) days from receipt of notice of said failure.

(c) No person, who after having been prohibited from taking further examinations pursuant to subsection (b) above or pursuant to this subsection, twice fails a license qualification examination shall be permitted to take further examinations for a period of sixty (60) days from receipt of notice of said failure.

NOTE: Authority cited: Section 1682, Insurance Code. Reference: Sections 1670 and 1681, Insurance Code.

HISTORY

1. New article 5.5 and section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).

Article 5.6. Personal Lines Examination Exemption Request

§ 2182.1. Authority and Purpose.

NOTE: Authority cited: Stats. 2000, ch. 321, § 8, p. 2186. Reference: Sections 1625.5 and 1676, Insurance Code.

HISTORY

1. New article 5.6 (sections 2182.1–2182.5) and section filed 9–4–2001 as an emergency; operative 9–4–2001 (Register 2001, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealer of article 5.6 (sections 2182.1–2182.5 and Form LIC.PL1) and repealer of section by operation of Government Code section 11346.1(g) (Register 2003, No. 10).

§ 2182.2. Definitions.

NOTE: Authority cited: Stats. 2000, ch. 321, § 8, p. 2186. Reference: Sections 1625.5 and 1676, Insurance Code.

HISTORY

1. New section filed 9–4–2001 as an emergency; operative 9–4–2001 (Register 2001, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).

§ 2182.3. Personal Lines Examination Exemption Request.

NOTE: Authority cited: Stats. 2000, ch. 321, § 8, p. 2186. Reference: Sections 1625.5 and 1676(a)–(i), Insurance Code.

HISTORY

1. New section filed 9–4–2001 as an emergency; operative 9–4–2001 (Register 2001, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).

§ 2182.4. Applicant Qualifications.

NOTE: Authority cited: Stats. 2000, ch. 321, § 8, p. 2186. Reference: Sections 1625.5 and 1676(b)–(i), Insurance Code.

HISTORY

1. New section filed 9–4–2001 as an emergency; operative 9–4–2001 (Register 2001, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).

§ 2182.5. Deadline for Exemption Request.

NOTE: Authority cited: Stats. 2000, ch. 321, § 8, p. 2186. Reference: Section 1676(i), Insurance Code.

HISTORY

1. New section filed 9–4–2001 as an emergency; operative 9–4–2001 (Register 2001, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealer of section and Form LIC.PL1 by operation of Government Code section 11346.1(g) (Register 2003, No. 10).

Article 5.7. Producer Licensing Background Review Guidelines

§ 2183. Authority and Purpose.

These regulations are promulgated pursuant to the authority granted the Commissioner under the provisions of Section 12921(a) of the Insurance Code. The purpose of these regulations is to set forth licensing background review guidelines for use in determining the denial, suspension, revocation, and/or restriction of an insurance producer license or license application.

NOTE: Authority cited: Section 12921, Insurance Code. Reference: Section 12921, Insurance Code.

HISTORY

1. New article 5.7 (sections 2183–2183.4) and section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

§ 2183.1. Applicability.

The producer licensing background review guidelines described in Sections 2183, 2183.1, 2183.2, 2183.3, and 2183.4 shall apply to all persons who possess, or who have applied for, any insurance producer license governed by the Insurance Code, including, but not limited to agent, broker, solicitor, bail agent, bail solicitor, or adjuster.

NOTE: Authority cited: Section 12921, Insurance Code. Reference: Section 12921, Insurance Code.

HISTORY

1. New section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

§ 2183.2. Substantial Relationship Criteria for Crimes or Wrongful Acts.

For purposes of denial, suspension, revocation, and/or restriction of a license or license application, statutes within the Insurance Code list specific grounds and also allow for action based upon findings that include, but are not limited to, the licensee or applicant lacking integrity, having a poor business reputation, or that permitting the licensee or applicant to hold an insurance license is against the public interest. The following is a partial list of crimes or acts that are substantially related to the qualifications, functions or duties of an insurance licensee:

(a) Any felony conviction;

(b) A misdemeanor conviction which evidences present or potential unfitness to perform the functions authorized by the license in the manner consistent with the public health, safety, and welfare, including but not limited to, soliciting, attempting, or committing crimes involving the following:

(1) Dishonesty or fraud;

(2) Any conviction arising out of acts performed in the business of insurance or any other licensed business or profession;

(3) Theft;

(4) Sexually related conduct affecting a person who is an observer or non–consenting participant in the conduct or convictions, or which requires registration pursuant to the provisions of Section 290 of the Penal Code;

(5) Resisting, delaying, or obstructing a public officer in violation of Penal Code Section 148;

(6) Any act or offense wherein the person willfully causes injury to the person or property of another;

(7) Violation of a relation of trust or confidence, or a breach of fiduciary duty;

(8) Multiple convictions which demonstrate a pattern of repeated and willful disregard for the law.

(c) Any act which demonstrates a willful attempt to derive a personal financial benefit through the nonpayment or underpayment of taxes, assessments, or levies duly imposed upon the licensee or applicant by federal, state or local government or a willful failure to comply with a court order.

NOTE: Authority cited: Section 12921, Insurance Code. Reference: Sections 1668, 1668.1, 1668.5, 1669, 1738, 1742, 1743, 1805, 1806, 1807, 14026.5, 14028, 14028.5, 14061, 14061.5, 15011, 15018, 15018.5, 15039 and 15039.5, Insurance Code.

HISTORY

1. New section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

§ 2183.3. Weight of Substantially Related Acts.

In considering discipline of a license or license application, the weight to be accorded to a substantially related crime or act described in Section 2183.2 (a), (b), or (c) may be determined by the application of guidelines including, but not limited to, the following:

(a) The extent to which the particular act or omission has adversely affected other person(s) or victim(s), including but not limited to, insurers, clients, employers or other persons, and the probability such adverse effects will continue;

(b) The recency or remoteness in time of the act, misconduct, or omission;

(c) The type of license applied for or held by the licensee or applicant involved;

(d) The extenuating or aggravating circumstances surrounding the act, misconduct, or omission;

(e) Whether the licensee or applicant has a history of prior license discipline, particularly where the prior discipline is for the same or similar type of conduct.

NOTE: Authority cited: Section 12921, Insurance Code. Reference: Sections 1668, 1668.1, 1668.5, 1669, 1738, 1742, 1743, 1805, 1806, 1807, 14026.5, 14028, 14028.5, 14061, 14061.5, 15011, 15018, 15018.5, 15039 and 15039.5, Insurance Code.

HISTORY

1. New section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

§ 2183.4. Criteria for Evaluating Rehabilitation.

The Commissioner may consider all of the evidence presented, including evidence offered by the licensee or applicant, to determine whether the licensee or applicant has sufficiently rehabilitated from the prior act, misconduct, or omission such that the licensee or applicant is fit to hold an insurance license. When evaluating the rehabilitation of an applicant for an insurance license, or when considering the suspension, revocation, and/or restriction of an insurance license, on the grounds of conviction of a crime or the commission of some other wrongful act, the Commissioner may consider criteria, including, but not limited to, the following:

(a) Nature and severity of the act, misconduct, or omission;

(b) Total criminal record;

(c) The time that has elapsed since commission of the act, misconduct, or omission; however, the mere passage of time without unlawful or wrongful activity is not alone sufficient to establish rehabilitation;

(d) Whether the licensee or applicant has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee or applicant; however, termination of probation or parole or obtaining a Penal Code Section 1203.4 expungement of the conviction, or other comparable orders of a court, including federal courts, are not alone sufficient evidence of rehabilitation;

(e) Whether the licensee or applicant has made any restitution or done anything to recompense the injured party or to alleviate the wrong or damage caused by the act, misconduct, or omission;

(f) Significant and/or conscientious involvement in community or privately–sponsored programs designed to provide social benefits or to ameliorate social problems.

NOTE: Authority cited: Section 12921, Insurance Code. Reference: Sections 1668, 1668.1, 1668.5, 1669, 1738, 1742, 1743, 1805, 1806, 1807, 14026.5, 14028, 14028.5, 14061, 14061.5, 15011, 15018, 15018.5, 15039 and 15039.5, Insurance Code.

HISTORY

1. New section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

Article 6. Disclosure of Compensation Received from Premium Financers

§ 2185. Disclosure of Compensation.

(a) Any person engaged in business as an insurance agent or broker who accepts compensation for arranging, directing, or performing services in connection with a premium financing agreement shall disclose in writing to the insured prior to the execution of the premium finance agreement the amount of compensation such insurance agent or broker is to receive from the premium financer on account of that premium finance agreement.

(b) The disclosure required under subsection (a) shall be made in the following form:

[The next page is 526.7.]

STATEMENT OF COMPENSATION TO BE PAID TO INSURANCE AGENT OR BROKER BY LENDER

This statement is required by provisions of California Insurance Code Section 778.2.

1. Name of Insured: _____

2. Last of Financed Policies and Amount of Premium Financed on each Policy:

_____ $ _____
_____ $ _____
_____ $ _____
Total $ _____

3. Name and Address of Premium Financer (lender):

_____

4. Gross Finance Charge for Financing the Above Premiums:
$ _____

5. Total compensation to be received by the undersigned agent or broker from the lender by reason of the premium agreement relating to the above premiums (if compensation is contingent state the maximum compensation payable under any contingency):
$ _____

Dated: _____
(Insurance Agent or Broker)

(c) In lieu of the foregoing separate disclosure statement, said information may be contained in the premium finance agreement or other document, provided the premium finance agreement or other document contains all of the information set forth above and is signed by the insurance agent or broker.

NOTE: Authority cited: Section 778.2(b), Insurance Code.

HISTORY

1. New Article 6 (§2185) filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

Article 6.5. Prelicensing and Continuing Education

§ 2186. Authority and Purpose.

These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of Section 1749.7 of the California Insurance Code. The purpose of these regulations is to set forth the prelicensing education curriculum standards for approval of courses and providers of prelicensing and continuing education, and to set forth standards of conduct for students and providers of prelicensing and continuing education.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3 and 1749.4, Insurance Code.

HISTORY

1. New article 6.5 and section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

§ 2186.1. Definitions.

For purposes of these regulations:

(a) "Provider" means any institution or organization as described in Section 1749.4 of the California Insurance Code, including an authorized insurer, recognized agents' association or insurance trade association, and any accredited college, or university, or any other person or entity offering classes, courses, seminars, programs and self–directed study in insurance intended to satisfy the requirements of Sections 1749, 1749.3, 1749.31, 1749.8 or 10234.93(a)(4) of the California Insurance Code.

(b) "Provider director" means the individual within a provider organization with responsibility for the administration of the programs approved by the Commissioner pursuant to Sections 1749, 1749.3, 1749.31, 1749.8 and 10234.93(a)(4) of the California Insurance Code.

(c) "Certified provider" means a provider who or which has been determined by the Commissioner to have met the requirements of Section 2188 of this article.

(d) "Controlling person" means any of the following persons within a provider possessing decision making authority in matters pertaining to prelicensing and/or continuing education: a provider director, partner, corporate director, officer, shareholder owning a ten percent (10%) or more interest in the organization, or other person with decision making authority.

(e) "Instructor" means a person who conveys curricular content to students on behalf of a provider.

(f) "Student" means:

(1) an individual taking a prelicensing education course that is required as a prerequisite to obtaining a life agent, fire and casualty broker–agent, or personal lines broker–agent license; or,

(2) an individual taking an education course to satisfy the requirements of Sections 1749.3, 1749.31, 1749.8 and 10234.93(a)(4) of the California Insurance Code.

(g) "Classroom" means:

(1) any space sufficiently designed so that instructor(s) and students can communicate with a high degree of privacy and relative freedom from outside interference; or

(2) for continuing education courses only, classroom may include teleconferences with audio/visual interface, internet chat rooms, or other electronic devices used to accommodate technological changes.

(h) "Course" means any program of instruction taken or given to satisfy the requirements of Sections 1749, 1749.3, 1749.31, 1749.8 and 10234.93(a)(4) of the California Insurance Code.

(i) A "contact course" is a classroom presentation, seminar, workshop, conference, lecture, or teleconference with monitored attendance. A "class" is a contact course presentation.

(2) An "interactive course" is a continuing education course that allows for an agent or broker and the instructor or proctor to exchange information using technological mediums such as video, compact diskette (CD), digital versatile disc (DVD), internet chat room, or other similar form designed for the exchange of information electronically.

(3) A "self–directed course" is a continuing education course that is not an interactive course, with study material in text, video, audio cassette, compact diskette (CD), digital versatile disc (DVD), or other similar form designed for individual study by a licensee. Attendance monitoring is not required.

(4) A "combination course" is a course that includes both self–directed and contact course requirements to total a minimum of three (3) continuing education hours. It is mandatory for the student to complete the self–directed portion prior to completing the contact course portion of the course. Successful completion will be determined by the provider in the same manner as described in Sections 2188.6(c), (d) and (e).

(i) "Approved course" means a course for which the Commissioner has granted his written approval. The Commissioner reserves the right to reduce the hours requested if the course fails to meet all of the criteria set forth in these regulations.

(j) "Curriculum" is a statement describing the general content required in a course of study to satisfy the requirements of Sections 1749 et. seq. of the California Insurance Code. Each curriculum is approved by the curriculum board and the Commissioner.

(k) Original signature" means the provider director's actual signature. Original signatures are required on all provider and course applications and renewals, as well as on each "Prelicensing/Continuing Education Program Out–of–State Provider Jurisdiction Agreement" form (Form 446–40) and "Prelicensing and Continuing Education Provider Stipulation to Maintain Records Outside of California" form (Form 446–32). A provider may utilize either a controlled signature stamp, or a computer generated signature, or appoint an authorized designee for purposes of signing any other forms. Prior to using either a signature stamp or a computer generated signature, the provider must submit to the Department a

thorough explanation of the steps the provider has taken to ensure the security of either the stamp or computer facsimile. Prior to utilizing an authorized designee, the provider must submit to the Department a list of the names of the persons so authorized, along with a sample of each person's signature.

(*l*) "Electronic signature" means an assigned student log–in/log–out number from an approved provider that allows a student to log into a computer–based class presentation. The approved provider must maintain the time attendance of each student who participates in the computer–based course.

(m) "Electronic filing" is the method which the education provider submits the course rosters and class presentation schedules. The electric filing methods include, but are not limited to, the California Department of Insurance's Web site, electronic flat file, diskette, compact diskette (CD), or digital versatile disc (DVD).

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3, 1749.31, 1749.4, 1749.8 and 10234.93(a)(4), Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).
3. Amendment of section heading and amendment of subsection (f)(1) filed 6–13–2001 as an emergency; operative 1–1–2002 (Register 2001, No. 24). A Certificate of Compliance must be transmitted to OAL by 5–1–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6–13–2001 order transmitted to OAL 4–19–2002 and filed 6–3–2002 (Register 2002, No. 23).
5. Amendment of section and NOTE filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2187. Prelicensing Education for Fire and Casualty Broker–Agents.

(a) Any course taken to satisfy the prelicensing education requirement of Section 1749(a) of the California Insurance Code shall be in a classroom and shall use the general subject matter derived from the following curriculum:

I. GENERAL INSURANCE
- A. Basic Insurance
- 1. History
- 2. Concepts and Principles
- B. Insurance Contract Law
- C. The Insurance Marketplace
- 1. Distribution Systems
- 2. Producers
- 3. Insurers
- 4. Market Regulation

II. BASIC CONCEPTS OF PROPERTY AND LIABILITY INSURANCE
- A. Basic Legal Concepts: Tort Law
- B. Property and Liability Basics
- C. Property and Liability Policies: General Concepts

III. PERSONAL LINES INSURANCE
- A. Dwelling Insurance
- 1. Dwelling Insurance: General Concepts
- 2. Dwelling Fire/Homeowners Section I
- 3. Homeowners Section II / (Comprehensive Personal Liability)
- 4. Selected Homeowners Endorsements
- B. Inland Marine
- 1. Inland Marine: General Concepts
- 2. Inland Marine: Personal Insurance
- C. Government/Pools/Catastrophe – Property Insurance
- 1. Earthquake Coverage
- 2. FAIR Plan
- 3. National Flood Insurance
- D. Personal Auto
- 1. Personal Auto – General Concepts
- 2. Personal Auto – Liability/Medical/Uninsured Motorist
- 3. Personal Auto – Physical Damage/Miscellaneous
- 4. California Automobile Assigned Risk Plan (CAARP)
- E. Umbrellas and Excess Liability Insurance

IV. COMMERCIAL COVERAGES
- A. ISO Mobilized Commercial Lines Program
- B. Commercial Property
- 1. Commercial Property: General Concepts
- 2. Building and Personal Property Coverage Form
- 3. Causes of Loss Form(s)
- 4. Property Indirect Damage Insurance
- 5. Other Endorsements and Coverages
- C. Commercial General Liability
- 1. Commercial General Liability: General Concepts
- 2. CGL Coverage Form (Occurrence Basis)
- 3. Professional Liability and "Claims Made" Coverage
- 4. Umbrella and Excess Liability
- D. Commercial Crime
- E. Boiler, Machinery and Plate Glass
- F. Commercial Inland Marine
- G. Commercial Auto
- 1. Commercial Auto: General Concepts
- 2. Business Auto Coverage
- 3. Garage Auto Coverage
- 4. Truckers Coverage
- H. Farm
- I. National Flood – Commercial
- J. Businessowners
- 1. Businessowners: General Concepts
- 2. Businessowners Policy Property Coverages
- 3. Businessowners Policy Liability Coverages
- K. Ocean Marine
- L. Surety Bonds and General Bond Concepts
- M. Worker's Compensation
- N. Excess and Surplus Lines

V. HEALTH AND DISABILITY INCOME INSURANCE
- A. Health and Disability Insurance – General Concepts
- B. Medical Expense Insurance
- C. Disability Income Insurance
- D. Senior Health Products

VI. NEW DEVELOPMENTS
- A. Legal
- B. Insurance Products and Practices

(b) The examination required for licensure as a fire and casualty broker–agent pursuant to California Insurance Code Section 1676 shall be based on the subject matter reflected in the foregoing curriculum.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749 and 1749.1, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

§ 2187.1. Prelicensing Education for Life Agents.

(a) Any course taken to satisfy the prelicensing education requirement of Section 1749(c), effective January 1, 2002, of the California Insurance Code shall be in a classroom and shall use the general subject matter derived from the following curriculum:

I. GENERAL INSURANCE
- A. Basic Insurance
- 1. History
- 2. Concepts and Principles
- B. Contract Law
- C. The Insurance Marketplace
- 1. Distribution Systems
- 2. Producers
- 3. Insurers
- 4. Market Regulation – General

II. LIFE INSURANCE
A. Life Insurance: Basic Concepts
B. Types of Life Policies and Riders
C. Annuities
D. California Insurance Code Requirements for Policy Replacement and Flat Cancellation
E. The Life Insurance Contract
F. Taxation of Life Insurance Premium and Proceeds
G. Employee Benefits Plans: Life
H. Social Insurance System
I. General Concepts of Underwriting, Pricing and Claims
J. Financial Structure of Insurers
III. HEALTH and DISABILITY INCOME INSURANCE
A. Basic Disability Insurance Principles and Concepts
B. Medical Expense Insurance
C. Medicare and Medi-Cal Insurance
D. Long Term Care Insurance
E. HICAP Program – Health Insurance and Counselling Advocacy Program
F. Disability Income Insurance
G. Workers Compensation Insurance
1. General Concepts
2. Concept of 24-Hour Coverage
IV. NEW DEVELOPMENTS
A. Legal
B. Insurance Products and Practices

(b) The examination required for licensure as a life agent pursuant to California Insurance Code Section 1676 shall be based on the subject matter reflected in the foregoing curriculum.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749 and 1749.1, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).
3. Amendment of section heading and amendment of subsection (a) filed 6–13–2001 as an emergency; operative 1–1–2002 (Register 2001, No. 24). A Certificate of Compliance must be transmitted to OAL by 5–1–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6–13–2001 order transmitted to OAL 4–19–2002 and filed 6–3–2002 (Register 2002, No. 23).

§ 2187.2. Prelicensing Education on Ethics and the California Insurance Code.

(a) Any course taken to satisfy the prelicensing education requirement of Section 1749(d), effective January 1, 2002, of the California Insurance Code shall be in a classroom and shall use the general subject matter derived from the following curriculum:

I. GENERAL INSURANCE
A. Basic Insurance Concepts and Principles
B. Contract Law
C. Producers
D. Insurers
E. Marketing Regulation: General Concepts
II. PROPERTY and LIABILITY (Fire and Casualty and Personal Lines, effective January 1, 2002)
A. General
B. Personal Auto
C. Excess and Surplus Lines
III. LIFE INSURANCE (Life Insurance only)
A. Life Insurance
B. Annuities
IV. HEALTH & DISABILITY INCOME INSURANCE (excluding Personal Lines, effective January 1, 2002)
A. Health and Disability Income
B. Senior Health Products
VI. NEW DEVELOPMENTS
A. Legal
B. Insurance Products and Practices

(b) The examination required pursuant to Insurance Code Section 1676 shall be based on the subject matter in the foregoing curriculum.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749 and 1749.1, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).
3. Amendment of section heading and amendment of subsection (a) filed 6–13–2001 as an emergency; operative 1–1–2002 (Register 2001, No. 24). A Certificate of Compliance must be transmitted to OAL by 5–1–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6–13–2001 order transmitted to OAL 4–19–2002 and filed 6–3–2002 (Register 2002, No. 23).

§ 2187.3. Prelicensing Education for Personal Lines Broker-Agent.

(a) Any course taken to satisfy the prelicensing education requirement of Section 1749(b) of the California Insurance Code as effective January 1, 2002, shall be in a classroom and shall use the general subject matter derived from the following curriculum:

I. GENERAL INSURANCE
A. Basic Insurance
1. History
2. Concepts and Principles
B. Insurance Contract Law
C. The Insurance Marketplace
1. Distribution Systems
2. Producers
3. Insurers
4. Market Regulation
II. BASIC CONCEPTS OF PROPERTY AND LIABILITY INSURANCE
A. Basic Legal Concepts: Tort Law
B. Property and Liability Basics
C. Property and Liability Policies: General Concepts
III. PERSONAL LINES INSURANCE
A. Dwelling Insurance
1. Dwelling Insurance: General Concepts
2. Dwelling Fire/Homeowners Section I
3. Homeowners Section II/(Comprehensive Personal Liability)
4. Selected Homeowners Endorsements
B. Inland Marine
1. Inland Marine: General Concepts
2. Inland Marine: Personal Insurance
C. Government/Pools/Catastrophe – Property Insurance
1. Earthquake Coverage
2. FAIR Plan
3. National Flood Insurance
D. Personal Auto
1. Personal Auto – General Concepts
2. Personal Auto – Liability/Medical/Uninsured Motorist
3. Personal Auto – Physical Damage/Miscellaneous
4. California Automobile Assigned Risk Plan (CAARP)
5. Motorcycles
6. Recreational Vehicles
7. GAP Coverage
E. Umbrella and Excess Liability Insurance
F. Low-Cost Automobile Insurance
1. Be able to identify:
(a) What is low-cost automobile insurance?
(b) What are the costs for this insurance?
(c) Who is eligible to purchase low-cost automobile insurance?
(d) What are the cancellation and renewal procedures for low-cost automobile insurance?
(e) What are the coverages and limits available?
IV. NEW DEVELOPMENTS
A. Legal

B. Insurance Products and Practices

(b) The examination required for licensure as a personal lines broker–agent pursuant to California Insurance Code Section 1676 shall be based on the subject matter reflected in the foregoing curriculum.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749 and 1749.1, Insurance Code.

HISTORY

1. New section filed 6–13–2001 as an emergency; operative 1–1–2002 (Register 2001, No. 24). A Certificate of Compliance must be transmitted to OAL by 5–1–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–13–2001 order transmitted to OAL 4–19–2002 and filed 6–3–2002 (Register 2002, No. 23).

§ 2187.4. Prelicensing Curriculum for Personal Lines Licensees To Become Fire and Casualty Broker–Agents.

(a) Any course taken to satisfy the prelicensing education requirement of Section 1749(f), of the California Insurance Code shall be in a classroom and shall use the general subject matter derived from the following curriculum.

I. Commercial Coverages
A. ISO Modulized Commercial Lines Program
B. Commercial Property
1. Commercial Property: General Concepts
2. Building and Personal Property Coverage Form
3. Causes of Loss Form(s)
4. Property Indirect Damage Insurance
5. Other Endorsements and Coverages
C. Commercial General Liability
1. Commercial General Liability: General Concepts
2. CGL Coverage Form (Occurrence Basis)
3. Professional Liability and "Claims Made Coverage
4. Umbrella and Excess: Liability
D. Commercial Crime
E. Boiler, Machinery and Plate Glass
F. Commercial Inland Marine
G. Commercial Auto
1. Commercial Auto: General Concepts
2. Business Auto Coverage
3. Garage Auto Coverage
4. Truckers Coverage
H. Farm
I. National Flood — Commercial
J. Businessowners
1. Businessowners: General Concepts
2. Businessowners Policy Property Coverages
3. Businessowners Policy Liability Coverages
K. Ocean Marine
L. Surety Bonds and General Bond Concepts
M. Worker's Compensation
N. Excess and Surplus Lines
II. Health and Disability Income Insurance
A. Health and Disability Insurance — General Concepts
B. Medical Expense Insurance
C. Disability Income Insurance
D. Senior Health Products

(b) The examination required for licensure for a personal lines broker–agent who applies to become a fire and casualty broker–agent, pursuant to California Insurance Code Section 1676 shall be based on the subject matter reflected in the foregoing curriculum.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749 and 1749.1, Insurance Code.

HISTORY

1. New section filed 11–18–2002 as an emergency; operative 11–18–2002 (Register 2002, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3–20–2003 as an emergency; operative 3–20–2003 (Register 2003, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–18–2003 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 3–20–2003 order transmitted to OAL 7–10–2003 and filed 8–21–2003 (Register 2003, No. 34).

§ 2188. Provider Qualification, Certification and Renewal.

(a) Original Provider Certification

(1) Every person desiring to be certified as a provider shall submit to the Commissioner a provider application on Form 446–2 ([Prelicensing/Continuing Education Program Provider Certification/Renewal Application] REV. 9/95), incorporated by reference herein, along with the filing fee specified in California Insurance Code Section 1751.1. The provider application shall request information that shall include but not be limited to the following:

(i) the name and qualifications (experience, professional designations, degrees, licenses held) of the provider director;

(ii) whether the provider director, or a controlling person of a provider organization, has been convicted of a crime, refused a professional, occupational or vocational license or has had such a license suspended, restricted or revoked by any licensing authority, or been fined or placed on probation by an administrative agency;

(iii) the location, including street address, city, telephone number and contact person, of records required to be maintained by provider; if records are to be kept outside of California, Form 446–32 as described in Section 2188.4(e) must be completed and signed by the Provider Director;

(iv) the attendance record forms proposed for use meeting the requirements delineated in Section 2188.5(b);

(v) the provider's status with the Council for Private Post Secondary and Vocational Education;

(vi) whether the provider is a sole proprietorship, partnership, association or corporation;

(vii) certification that no course shall be offered for credit unless the provider has been certified as a provider by the Commissioner;

(viii) the original signature of the provider director certifying accuracy of information provided; and

(ix) the full legal name, social security number, and date of birth of each controlling person.

(2) No provider shall be certified if the application referred to above is incomplete. The Department shall inform all provider applicants in writing within seven days from the Department's receipt of the provider application either that it is complete and accepted for filing, or that it otherwise contains deficiencies requiring correction. Incomplete provider applications shall remain active for one year unless withdrawn by the applicant. After one year, a new application is required, along with the filing fee specified in California Insurance Code Section 1751.1. Notification that an application is complete does not necessarily mean the Department considers all information contained therein to be sufficient, and submission of insufficient information may be a basis for denial of provider certification. The Department shall decide whether to grant or renew provider certification within sixty days from its receipt of a completed application, however, the sixty–day time period shall be tolled during any such time that a provider applicant comes under formal investigation by the Department.

(3) The Commissioner may refuse to certify a provider if:

(i) the applicant or any controlling person is not properly qualified to perform the duties of a provider;

(ii) the granting of certification would be against the public interest;

(iii) the applicant or any controlling person is not of good business reputation;

(iv) the applicant or any controlling person is lacking in integrity;

(v) the applicant or any controlling person has been refused a professional, occupational or vocational license, had such a license suspended, revoked, or restricted, or been fined or placed on probation by any licens-

ing authority for reasons other than the applicant's or controlling person's failure to meet the licensing authority's technical requirements for licensure;

(vi) the applicant or any controlling person has knowingly, willfully, or recklessly made any misstatement in any application to the Commissioner or in a document filed in support of such application, or has made a false statement in testimony given under oath before the Commissioner or any other person acting in his stead;

(vii) the applicant or any controlling person has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner;

(viii) the applicant or any controlling person has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with him to the danger of loss;

(ix) the applicant or any controlling person has been convicted of a felony, a misdemeanor denounced by any law regulating insurance, a public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in the acceptance, custody, or payment of money or property, or a public offense which indicates any potential for future conduct detrimental to students or the insurance industry;

(x) the applicant or any controlling person has aided or abetted any person in an act or omission which would constitute grounds for certification denial of or disciplinary action under the California Insurance Code against the person aided or abetted; or

(xi) the applicant or any controlling person has permitted any person in his employ to violate any provision of the California Insurance Code.

(4) Every nonresident applicant for provider certification shall file with the Commissioner the agreement included on Form 446.40 ([Prelicensing/Continuing Education Program Out-of-State Provider Jurisdiction Agreement] REV. 9/95), incorporated by reference herein. The agreement shall give jurisdiction over and shall be binding upon the applicant executing it. Service may be made upon the Commissioner under the circumstances described in the agreement and in the manner provided in the Insurance Code.

(5) Upon the filing of an original or renewal application to be certified as a provider, the Insurance Commissioner may make such investigation and require the filing of such supplementary documents, affidavits and statements as may be necessary to obtain a full disclosure of such information as will aid him in determining whether the prerequisites for the certification or renewed certification of said provider have been met.

(b) Renewal of Provider Certification

(1) Every person desiring to renew certification as a provider shall submit to the Commissioner a provider renewal application on Form 446-2 ([Prelicensing/Continuing Education Program Provider Certification/ Renewal Application] REV. 9/95), incorporated by reference herein.

(2) No provider certification shall be renewed if the application referred to above is incomplete. The Department shall inform all provider renewal applicants in writing within seven days from the Department's receipt of the provider renewal application either that it is complete and accepted for filing, or that it otherwise contains deficiencies requiring correction. Incomplete provider applications shall remain active for one year unless withdrawn by the applicant. After one year, a new application is required, along with the filing fee specified in California Insurance Code Section 1751.1. Notification that an application is complete does not necessarily mean the Department considers all information contained therein to be sufficient, and submission of insufficient information may be a basis for denial of provider certification. The Department shall decide whether to renew provider certification within sixty days from its receipt of a completed application, however, the sixty-day time period shall be tolled during any such time that a provider comes under formal investigation by the Department.

(3) Provider renewal applications shall be received by the Department not less than sixty days prior to the expiration of provider status to maintain continuity of certification.

(4) A provider with an expired certification is not permitted to offer any of its approved courses until such time as its active status has been renewed.

(c) A certified provider shall notify the Commissioner in writing no later than ten days following any change in any of the items listed in subdivision (a) (1) of this Section.

(d) A certified provider and applicant for certification shall obtain the Commissioner's written approval prior to using any fictitious name under which it acts in a capacity for which certification is required. A certified provider or applicant shall file with the Commissioner any change in or discontinuance of a true or fictitious name. The Insurance Commissioner may in writing disapprove the use of any fictitious or true name, other than the bona fide natural name of an individual, on any of the following grounds:

(i) the name is an interference with or is too similar to a name already filed and in use by another certified provider;

(ii) the use of the name might mislead the public in any respect; or

(iii) the provider or applicant has already obtained approval for the use of a fictitious name, and has not agreed to discontinue the use of that name. This subdivision shall not prevent a provider or applicant who has lawfully purchased or succeeded to the business or businesses of other providers from using for each such business not more than two additional names, true or fictitious, consisting of names used by the predecessor businesses in their conduct as certified providers.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3 and 1749.4, Insurance Code.

HISTORY

1. New section filed 4-15-93; operative 5-17-93 (Register 93, No. 16).
2. Repealer and new section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

§ 2188.1. Instructor Qualifications.

(a) An approved provider shall assure that each course approved to satisfy the requirements of California Insurance Code Sections 1749 or 1749.3 shall be taught or presented by an instructor who meets one of the following qualifications:

(1) three years experience within the last five years in the course subject matter, which experience may include holding an appropriate insurance license for the subject being taught, or

(2) possession of a college degree in the subject matter being taught, or a related recognized professional designation, or related recognized professional credentials in the subject matter being taught.

(b) The Department shall have the right to review existing records of instructors and direct the provider not to use an instructor who does not meet the instructor qualifications as set forth in this Section or does not adhere to other applicable requirements stated in these regulations.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3 and 1749.4, Insurance Code.

HISTORY

1. New section filed 4-15-93; operative 5-17-93 (Register 93, No. 16).
2. Repealer and new section filed 8-23-96; operative 9-22-96 (Register 96, No. 34).

§ 2188.2. Course Approval.

(a) Every provider desiring to obtain approval of a course shall submit to the Commissioner, on Form 446-3 ([Prelicensing/Continuing Education Program Course Approval Application] REV. 3/06), as set forth in Section 2188.23, a course approval application, along with the applicable filing fee specified in California Insurance Code Section 1751.1. The course approval application form shall request information which shall include but not be limited to the following:

(1) the title of the course;

(2) a detailed statement of how each specific course is relevant to insurance topics or insurance products;

(3) a detailed outline of approximately one (1) page per hour of instruction for a contact course, including the time each topic is being presented; or a copy of all materials presented to each student and the time each topic is being presented.

(4) the number of credit hours requested for the course and how the number was determined;

(5) the applicable license type(s) of the intended audience;

(6) an agenda showing the beginning and ending times, breaks, and time allotted for exams, if given;

(7) the examination proposed to be used for the course when completion by examination is required; the exam shall include the answers along with a page and paragraph reference for each answer to the source material; and a statement on how the provider will maintain the integrity of the examination including a page and paragraph reference to the source book(s) for the answers; the length of time students have to complete a course; a copy of the exam instruction sheet that goes to the students; an explanation of how a course's completion date is determined, who maintains control of the answer key, what constitutes a passing grade and the provider's procedures in the event that a student fails an exam;

(8) when using another vendor's source material as the basis for the course, a current letter of authorization from the author or publisher;

(9) whether the course is open to the public; and

(10) the original signature of the provider director certifying accuracy of information provided.

(b) Every provider desiring to obtain approval of a contact course shall advise the Insurance Commissioner of the course's proposed location, including street address, city, state and zip code, and dates and time of the course. Such information shall be received at least fourteen days before the course is scheduled to begin. The provider shall provide this information on Form 446–12 ([Class Presentation Schedule Form] REV 11/05) as set forth in Section 2188.24.

(c) Any requests for course approval shall be received by the Department not less than thirty (30) days prior to the date of the course offering. The Department shall inform all providers and provider applicants submitting such requests within seven (7) days from the Department's receipt of an application whether it is complete and accepted for filing, or that it otherwise contains deficiencies requiring correction. Incomplete course applications shall remain active for one (1) year unless withdrawn by the applicant. After one (1) year, a new application is required, along with the applicable filing fee specified in California Insurance Code Section 1751.1. Notification that an application is complete does not necessarily mean the Department considers all information contained therein to be sufficient, and submission of insufficient information may be a basis for denial of course approval. The Department shall decide whether to approve or reject a course within thirty (30) days of its receipt of a request, however the thirty–day (30) time period shall be tolled during any time that a provider or provider–applicant comes under formal investigation by the Department.

(d) All advertisements for approved courses shall include the name of the provider, course title as approved by the Commissioner, license type for which the course is approved and the credit hour(s) assigned. No course shall be advertised as approved for credit by the Insurance Commissioner until approved in writing by the Insurance Commissioner.

(e) A course may be advertised as submitted for approval if a complete filing pursuant to Section 2188.2(a) has been submitted within the time specified by Section 2188.2(c), and if such advertisement includes an advisement, in at least the same size type as any language regarding the course having been submitted for approval, that the course is pending approval.

(f) Minor changes to courses that do not affect course content or presentation time should be reported in letter form not less than thirty (30) days prior to implementation of the change. A new edition of a book with approximately the same content may be considered a minor change.

(g) Major changes that affect presentation time or that materially alter the course content shall be filed as a new course. The course application shall be received by the Department not less than thirty (30) days prior to the date of the first course offering using the new material. Use of a different source book is considered a major change.

(h) Any changes regarding the location or date of any previously approved course, or notification of any additional date or location offering of a previously approved course shall be submitted on Form 446–12 ([Class Presentation Schedule Form] REV 11/05) as set forth in Section 2188.24, and such notification must be received by the Commissioner at least ten (10) days prior to the course offering. Late submission of a class presentation schedule must be accompanied by a letter of explanation signed by the provider director, in order for the Department to consider the course for approval. Continued noncompliance with the notification requirements of this subsection, including any failure to submit a letter of explanation, shall be considered grounds for the rescission of a provider's certification.

(i) Credit hours for contact courses, such as seminars, workshops or conferences, are determined using a fifty (50) minute hour. Credit for self–directed programs will be determined using a sixty (60) minute hour. Fractional hours or credit of less than one (1) hour will not be granted.

(j) No student shall receive contact instruction for more than eight (8) hours per day.

(k) Subjects qualifying for continuing education course approval shall include, but not be limited to, insurance contract analysis, risk management techniques, and rating and classification sessions. The overriding consideration in determining whether a specific program or course qualifies for continuing education credit is that it be a structured learning program which contributes directly to the professional or technical competence of the individual licensed. Courses on nontraditional insurance products or programs may be acceptable if the course contributes to the professional or technical competence of the individual person in the capacity for which they are licensed.

(*l*) Contact and self–directed course subjects that do not qualify for continuing education course approval shall include but not be limited to: sales training, communication skills, motivational training, meetings offered by insurers to launch new products or programs, and self–improvement programs.

(m) Combination courses having identical content in both the self–directed and contact portions of the course may not be approved. Combination courses having identical content in both the self–directed and contact portions of the course may be subject to a reduction in requested hours.

(n) Courses may fail to qualify for continuing education credit if the subject matter is deemed to be too basic, or is not at least as comprehensive as any applicable portion of the prelicensing curriculum. Courses which have, as a majority of their allocated time, general subject matter such as economics, demographics, taxation and law will be decided on a case by case basis. Courses on retirement planning, financial planning and estate planning may not qualify if the course curriculum does not reflect a substantial allocation of course time to training the agent to provide product– specific information to insurance consumers.

(o) No course approved for prelicensing or continuing education credit shall be construed to be endorsed by the Commissioner.

(p) Only an approved provider can offer and schedule an approved course; providers cannot delegate this authority to instructors or other parties.

(q) When scheduled courses are cancelled, providers must take reasonable efforts to notify all registrants and maintain documentation of those efforts.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749.2–1749.6 and 1749.8, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).
3. Amendment of subsections (a), (a)(3), (b), (c) and (f)–(i), repealer and new subsection (*l*), new subsection (m), subsection relettering and new NOTE filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2188.23. Prelicensing/Continuing Education Program Course Approval Application Form 446–3.

Producer Licensing — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

Instructions:	**Department Use Only:**
▫ This form must be completed for each course to be approved. ▫ A completed application with the proper attachments and filing fee must be received in the Department at least **30 days** prior to the first course presentation. ▫ Courses must be at least one hour, no fractional hours are granted. ▫ Ethics and Annuity course applications must include responses to the guideline questions located below.	Course #: _____ Approval period: _____ Credit Hours: _____ Category code: _____

First course presentation date:	Provider Number:	Phone Number: ( )

Provider Name:

Address:
Street City State Zip

Course Title:*

Check one course type:
☐ Prelicensing ☐ Continuing Education

☐ Prelicensing course hours:

☐ 12–hour ☐ 20–hour ☐ 32–hour ☐ 40–hour ☐ 52–hour

If continuing education, is this course intended to meet any statutory requirements? ☐ No ☐ Yes (if yes, indicate requirement below)

☐ California Long–Term Care
☐ 24–Hour Care Coverage
☐ California Partnership for Long–Term Care
☐ Annuity ☐ 8–Hour ☐ 4–Hour
☐ Ethics ☐ 4–Hour ☐ 2–Hour

Instruction Method:

Contact:	Non–Contact:
☐ Seminar	☐ Audio Cassette
☐ Workshop	☐ Video Tape
☐ Conference	☐ Correspondence/Text Book
☐ Classroom/Lecture	☐ Computer Diskette
☐ Teleconference (monitored)	☐ Internet
	☐ Other:

License Type(s): (check one or more) ☐ Fire and Casualty ☐ Personal Lines ☐ Life ☐ Bail

Number of continuing education course credit hours requested (Note: partial hours will not be accepted):

Number of times to be given during approval period?	Include on Department's list of courses open to public? ☐ Yes ☐ No

Is this course part of a designation program" ☐ Yes ☐ No If so, which program?

For Department use only:
Course approved Course **not** approved.

_____

_____

By: _____
Education Section Staff Signature Date

*Advertising and course materials must use this exact title. Courses based on another provider's material must be approved by that provider and must use same name.

REQUIRED ATTACHMENT CHECKLIST:

A. For Contact (Interactive) Courses:

1. A detailed statement on how the course is relevant to insurance topics and insurance products.
2. A detailed outline of approximately one page per hour of instruction including the time each topic is being presented.
3. A copy of all materials presented to each student if a detailed outline is not submitted with application.
4. An agenda showing the beginning and ending times, breaks, and time allotted for exams, if applicable.
5. A completed Class Presentation Schedule form for each presentation.
6. A current authorization letter from the author or publisher if using another vendor's source material as the basis for the course.
7. California prelicensing curriculum and educational objectives with every line page–referenced to the source book(s) used. **(For Prelicensing Courses Only)**

B. For Non–Contact (Non–Interactive) Courses:

1. A detailed statement on how the course is relevant to insurance topics and insurance products.
2. Audio cassette, video tape, computer diskette, text book for the course or copy of the text cover, copyright page and table of contents if using another vendor's pre–approved material/book
3. Internet courses must include your Internet address, security measures, log–on and password for our review of course(s). Answers to exam questions must reference section and screen for answer source.
4. A final examination with the questions scrambled (not in chapter order).
5. Answers to all exam questions with page and paragraph referencing to the source book(s) used.
6. A current authorization letter from the author or publisher if using another vendor's source material.
7. Copy of instruction sheet sent to students.

C. Ethics Training Course Questions:

1. Describe how this course contributes to an agent's understanding of his/her ethical responsibilities.
2. Point out where in the course examples of "good" licensee conduct are given, as well as examples of "bad" licensee conduct.
3. Explain how this course contributes to an agent's understanding of the complexities of ethical decision– making within the context of insurance transactions.
4. Describe where in the coursework an agent may find tools that are provided to help the agent identify, prevent, and resolve ethical dilemmas that arise in the course of conducting insurance business.
5. How will the content of this course contribute to the producers understanding of proper vs. improper, honest vs. dishonest behavior?
6. Please provide two samples of licensee conduct you will use in this course to contrast ethical with unethical behavior and details supporting the judgment of ethical or unethical behavior.
7. Identify how this course demonstrates to whom the licensee "owes" an ethical responsibility in this course and how this course will help the licensee understand his or her ethical responsibilities to such an entity.
8. How will this course help the licensee distinguish between legal and ethical behavior and legal but unethical behavior?

D. Four–Hour Annuity Training Course Questions:

1. Illustrate with examples how this course provides an enriched and more thorough education than the training in Section IV or Section IX from the "California Department of Insurance 2004 Annuity Training Outline, Topics To Be Included in 8–Hour Annuity Training Course".
2. Point out where in the course the examples of how annuity contract provisions impact the senior consumer (Section IV, "How fixed, variable, and index annuity contract provisions affect consumers", from the California Department of Insurance 2004 Annuity Training Outline, Topics To Be Included in 8–Hour Annuity Training Course) OR where in the course there are examples of proper and improper annuity sales practices discussed (Section IX, "Introduce sales practices for California insurance agents" from the California Department of Insurance 2004 Annuity Training Outline, Topics To Be Included in 8–Hour Annuity Training Course).
3. Explain how this course contributes to an agent's understanding of the laws governing the design of annuities and the sale of annuity products to seniors in California.
4. Describe where in the course there are tools provided to assist an agent to identify when an annuity product and/or an annuity sales practice are out of compliance with the law.

CERTIFICATION: I certify under penalty of perjury that I have read and understand the information and requirements contained in this application, that all statements are true and nothing has been withheld which would influence a complete evaluation of this course.

Original Signature of Provider Director Date

Printed Name of Provider Director

PLEASE SEND THIS COMPLETED APPLICATION ALONG WITH THE PROPER ATTACHMENTS AND FILING FEE TO:

California Department of Insurance
Producer Licensing Bureau–Education Section
P.O. Box 957
Sacramento, CA 95814–0957

Filing fees:
$32 per Continuing Education Course
$64 per Prelicensing Education Course

Make check payable to: California Department of Insurance

Course applications must be received in this office at least 30 days prior to the first course presentation date. No education credit will be granted prior to the 30th day from receipt of the completed application. Course advertisements for pending courses must clearly state that the course has been submitted and is pending approval, if the course application is complete and submitted within the appropriate time frame. EDUCATION SECTION INQUIRIES: (916) 492–3064

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.4, 1749.8 and 10234.93(a)(4), Insurance Code.

HISTORY

1. New section filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2188.24. Class Presentation Schedule Form 446–12.

Producer Licensing — Education Section
320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064
www.insurance.ca.gov

Instructions:

- Type or print clearly. USE A SEPARATE SHEET FOR EACH CLASS PRESENTATION.
- To inform the Department of a new class, mark NEW box and provide all pertinent information below.
- To notify the Department of a change to a class schedule previously submitted, mark CHANGE, give the original date, time, location and provide new information below.
- To cancel a class previously submitted, mark CANCEL and complete information below.
- This completed form must be received by the Department at least 14 days prior to the original class presentation. Subsequent presentations must be received at least 10 days prior to class presentation. No faxes will be accepted.
- Late schedules may not be accepted and attendees may not receive continuing education credit.
- The information provided below must match the information on the certificate of completion and the provider roster.

CHECK ONE: New ☐ Cancel ☐ Change ☐

Original Date/Time:
Original Location:
Combination Course ☐

In–House Offering ☐
(If marked this will not show on Department's Web site Provider and Course Search.)

Provider ID #:
Provider Name

Course ID#:	Credit Hours:	Instructor Name:	
Course Name:			
Start Date*:	Start Time:	End Date:	End Time:
	Military Time		Military Time

*If course spans more than one day, each day must be listed in Daily Presentation Schedule chart below.

Location of Presentation:

Street:	Room/Suite:	
City:	State:	Zip:

Daily Presentation Schedule: Times must be shown in military time (i.e. 8:00 AM = 0800; 2:00 PM = 1400)

Day	Date: (month/day/year)	Begin Time	End Time
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

(Attach sheet for additional days)

I certify that the class information provided here is true and correct to the best of my knowledge. Any changes will be provided to the Department promptly.

Original Signature of Provider Director Date

Printed Name of Provider Director ( ) Phone Number

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Section 1749.1, Insurance Code.

HISTORY

1. New section filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2188.3. Course Renewal.

(a) Every provider desiring to renew approval of an unchanged course or a course with only minor changes shall submit to the Insurance Commissioner on Form 446–38, [(Prelicensing/ Continuing Education Program Course /Renewal Application)(REV 9/95], incorporated by reference herein, a course renewal application, along with the applicable renewal fee specified in California Insurance Code Section 1751.1. The course renewal application form shall request information which shall include but not be limited to the following:

(1) the title of the course and Department of Insurance approval number;

(2) the number of credit hours currently assigned;

(3) for contact courses:

(i) a certification stating that the course remains unchanged from its last approval, signed by the provider–director; and

(ii) for minor changes not affecting time or course content, a course outline and agenda highlighting the changes made;

(4) for self–directed courses:

(i) a copy of all material(s) received by the student, the examination proposed to be used for the course, including the answers along with a page and paragraph reference for each answer to the source material;

(ii) a statement on how the integrity of the exam will be maintained; including a page and paragraph reference to the source book(s) for the answers; the length of time students have to complete a course; a copy of the exam instruction sheet that goes to the students; an explanation of how a course's completion date is determined, who maintains control of the answer key, what constitutes a passing grade and the provider's procedures in the event that a student fails an exam; and

(iii) when using another vendor's source material as the basis for the course, a current letter of authorization from the author or publisher; and

(5) an original signature of the provider director certifying accuracy of information provided.

(b) The Department reserves the right to revise the number of credit hours previously assigned for courses submitted for renewal approval.

(c) Course renewal applications shall be received by the Department not less than sixty days prior to the expiration of the course's approval to ensure continuity of the approval status.

(d) No provider shall be permitted to offer for continuing education credit a course with an expired status until such time as the active approval status of the course has been renewed.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1 and 1749.3, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

§ 2188.4. Maintenance of Records.

(a) All providers shall maintain completed instructor qualification information on Form 446–4 ([Prelicensing/Continuing Education Program Instructor Qualification Form] REV. 9/95), incorporated by reference herein.

(b) All providers shall maintain records of enrollments, and/or registrations, provider rosters, examination answer sheets and grades of students attending approved courses. Prelicensing education providers shall also maintain student resident addresses and telephone numbers.

(c) All providers shall maintain attendance records on forms approved by the Commissioner pursuant to Section 2188.5 (b).

(d) Records of attendance in accordance with this Section shall be maintained by the provider (including the local chapter of educational entity) for classroom programs referred to in Insurance Code Section 1749.4 (a) through (e).

(e) Provider records are to be maintained for a period of five (5) years and must be made available to the Insurance Commissioner for inspection and copying immediately upon request. All records of providers with an office in this State, or which are otherwise doing business in this State, shall be maintained at a location within the State unless Form 446–32 ([Prelicensing and Continuing Education Provider Stipulation to Maintain Records Outside of California] Rev. 8/96), incorporated by reference herein, is submitted by the provider director. Failure to comply with this subdivision shall be grounds for rescission of a provider's certification.

(f) Providers shall maintain records such as bank statements, ledgers, journals, receipt books, invoices, and checks, which establish an audit trail of all fees collected from and refunded to students for prelicensing and continuing education courses.

(g) Providers shall maintain copies of all advertisements, mailers and solicitations used in connection with the advertising or offering of prelicensing and continuing education courses to the public. Providers are not required to retain such items for a period in excess of two years, unless they have been notified by a representative of the Department of Insurance that a longer retention period is required.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3, 1749.4 and 1749.5, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

§ 2188.5. Successful Completion of Prelicensing Courses.

(a) A student's successful completion of a course intended to meet the prelicensing education requirements referred to in California Insurance Code Section 1749 shall be by attending one–hundred percent (100%) of a scheduled course.

(b) Course attendance shall be determined by the provider completing and maintaining a daily attendance record, at both the beginning and end of each session. Such attendance record can be maintained on Form 446–5 (Prelicensing/Continuing Education Program Course Attendance Record and Verification Form) REV. 8/96), incorporated by reference herein, or on a form selected by the provider, as long as the form contains the following minimum requirements:

(1) name, signature, social security number and insurance license number (if any) of the student;

(2) provider name and Department of Insurance certification number;

(3) course title and Department of Insurance approval number;

(4) date and location of course; and

(5) whether the record is for the beginning or end of a session.

(c) Providers of courses referenced in California Insurance Code Section 1749.4 (f) are exempt from the attendance record keeping requirements of Section 2188.5 (b) above. A student's successful completion of such courses will be by obtaining a passing grade of at least seventy percent (70%) on a final examination, or an instructor's certification that such student attended at least eighty percent (80%) of the scheduled course.

(d) The provider/instructor has the authority to withhold credit for program completion when, in his or her opinion, the student did not pay satisfactory attention, or otherwise failed to demonstrate acceptable student conduct in class.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1 and 1749.3, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

§ 2188.6. Successful Completion of Continuing Education Courses.

(a) Students shall attend all of a scheduled contact course; any exceptions must be approved by the instructor or provider director and must not violate the minimum attendance requirements listed below in Section 2188.6 (b). The provider/instructor has the authority to withhold credit for program completion when, in his or her opinion, the student did not pay satisfactory attention or otherwise failed to demonstrate acceptable student conduct in class.

(b) Except as set forth in other subsections of this Section, successful completion of a contact course referred to in California Insurance Code

Sections 1749.4 (g) shall be by attending at least eighty percent (80%) of a scheduled course.

(c) Course attendance shall be determined by the provider completing and maintaining a daily attendance record, at both the beginning and end of each session, in the same manner as described in Section 2188.5 (b).

(d) Providers of courses referenced in California Insurance Code Section 1749.4 (f) are exempt from the attendance record keeping requirements of subsection 2188.5 (b) above. A student's successful completion of such courses will be by obtaining a passing grade of at least seventy percent (70%) on a final examination or an instructor's certification that such student attended at least eighty percent (80%) of the contact course.

(e) Students taking self–directed courses must meet the provider's established criteria for acceptable work. Successful completion of self directed courses shall mean obtaining a passing grade of at least seventy percent (70%) on a final examination. The final examination shall be graded by the approved provider. The provider shall issue certificates of completion only to those students who have passed the final examination.

(f) Interactive courses, consisting of only video or audio programs, conducted in supervised environments involving attendance monitoring, such as work stations or conference rooms, may qualify for continuing education credit without the use of a final examination. A student's successful completion of such a course shall be by attending all of the scheduled time; any exceptions must be approved by an instructor or provider director and must not violate the minimum attendance requirements. Attendance shall be verified in accordance with Section 2188.5(b), by any approved provider.

(g) No course shall be taken for credit more than once within a two (2) year license period.

(h) Students licensed as a life agent and/or a fire and casualty broker–agent shall complete courses, programs of instruction, or seminars which follow a prescribed outline and have been approved by the Commissioner on ethics as part of, and not in addition to, the continuing education requirements pursuant to California Insurance Code Section 1749.3. The minimum number of hours required on ethics is as follows:

(1) The life agent and/or fire and casualty broker–agent shall satisfactorily complete four (4) hours on ethics each license term.

(i) Students licensed as a personal lines broker–agent shall complete those courses, programs of instruction, or seminars which follow a prescribed outline and have been approved by the Commissioner on ethics as part of, and not in addition to, the continuing education requirements pursuant to California Insurance Code Section 1749.31. The minimum number of hours required on ethics is as follows:

(1) The personal lines broker–agent shall satisfactorily complete two (2) hours on ethics each license term.

(j) Excess ethics continuing education hours accumulated during any license term may not be carried forward to the next license term. Pursuant to Section 2188.6(g), no course shall be taken for credit more than once within a two (2) year license term.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3, 1749.31, 1749.4, 1749.8 and 10234.93(a)(4), Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).
3. Amendment of subsections (d) and (f), new subsections (h)–(j) and new NOTE filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2188.7. Successful Completion of Statutory Approved Courses.

Successful completion of courses referred to in California Insurance Code Section 1749.4 (a) through (e) shall mean:

(a) Having received a passing grade for the examination administered by the council, college or institute referred to in Insurance Code Sections 1749.4 (a) through (e); or,

(b) Students attending a program referred to in Insurance Code Sections 1749.4 (a) through (e) shall attend all of a scheduled class; any exceptions must be approved by the instructor or provider director and must not violate the minimum attendance requirement of eighty percent (80%) of the scheduled class. Students shall be awarded credits based on attendance and subject to the attendance record keeping requirements of Section 2188.5(b). The provider/instructor has the authority to withhold credit for program completion when, in his or her opinion, the student did not pay satisfactory attention, or otherwise failed to demonstrate acceptable student conduct in class.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749.3 and 1749.4, Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

§ 2188.8. Certificates of Completion.

(a) Certificates of completion shall be provided by the approved provider to any student successfully completing a prelicensing, continuing education, or training course. Duplicate certificates of completion shall be issued by providers upon request in the case of lost or destroyed certificates. Certificates of completion shall contain the following information:

(1) original signature of the student and the instructor, or the provider director, or in the case of supervised audio/video courses, the original signature of the provider director designee who supervised the course and verified attendance;

(2) the title and Department of Insurance course approval number of the course completed;

(3) the provider name, address, telephone number and Department of Insurance approval number;

(4) for contact courses, the date/s of the course taken, the date completed and the city, including street address and zip code, where taken;

(5) the number of hours approved for the course;

(6) a statement that submitting a false or fraudulent certificate of completion to the Commissioner may subject any application for an insurance license to denial, and any issued license to suspension or revocation; and

(7) certificates of completion or the records of final examination grades of courses taken to satisfy the requirements of California Insurance Code Section 1749.3, 1749.31, 1749.8 and 10234.93(a)(4) shall state that the student should retain the certificate for five (5) years.

(b) The provider shall provide the Commissioner with a roster of students given certificates of completion as follows:

(1) The prelicensing roster is to be submitted within ten (10) business days following the completion of the course.

(2) The continuing education roster is to be submitted thirty (30) calendar days following the completion of the course. Said roster shall include the name of the instructor if the instructor is requesting credit for the course.

(3) The roster shall be submitted through an electronic filing method which can include, but is not limited to, the California Department of Insurance's Web site, electronic flat file, diskette, compact diskette (CD), or digital versatile disc (DVD). Specific requirements for submitting rosters using one (1) of the methods noted above will be provided by the education unit.

(4) Submission of typed hard copy form (446–13), [(Provider Roster) Rev. 3/06], as set forth in Section 2188.83 or typed on a form selected by the provider, as long as the form contains the following minimum requirements, will only be accepted under special circumstances previously approved by the CDI:

(A) the name, social security number and insurance license number (if any) of the student;

(B) the provider name and Department of Insurance approval number;

(C) the course title and Department of Insurance approval number;

(D) the date and location of course including street address and zip code;

(E) the number of hours approved for the course; and

(F) the signature of the provider director certifying accuracy of information provided.

(c) Submission of a late roster shall be accompanied by a letter of explanation signed by the provider director. Continued noncompliance, including any failure to supply a letter of explanation, shall be considered grounds for the rescission of a provider's certification.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3, 1749.31, 1749.4, 1749.8 and 10234.93(a)(4), Insurance Code.

HISTORY

1. New section filed 4–15–93; operative 5–17–93 (Register 93, No. 16).
2. Repealer and new section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).
3. Amendment of section and NOTE filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2188.83. Provider Roster Form 446–13.

Producer Licensing — Education Unit

320 CAPITOL MALL
SACRAMENTO, CA 95814–4309
Information (916) 492–3064 — www.insurance.ca.gov

Important: This form must be submitted to the California Department of Insurance (CDI) within **10** days following the completion of the **prelicensing** course **and 30 days following the completion of the continuing education course. Late rosters may not be accepted.** ***Items marked with an asterisk (*) are not required for non–contact courses.***

Pre–licensing Course: ☐ Continuing Education Course: ☐
Contact course: ☐ Non–Contact course: ☐ Combination Course: ☐

Provider ID #: Provider Name:

Course ID #: Credit Hours: Course Name:
*Course Start Date: *Beginning Time: *End Time: Completion Date:
Military time (i.e. 1300 = 1:00 P.M.)

*Class location: _____

Street Address _____ Suite/Room _____

City _____ State _____ Zip Code _____

The CDI requests disclosure of a student's social security number pursuant to Insurance Code Sections 1749, 1749.2, 1749.3, 1749.4, 1749.5, 1749.7, and California Code of Regulations, Title 10, Chapter 5, Section 2188.8(b)(1). This information is requested so that the CDI can properly identify and assign credit to students who have completed prelicensing or continuing education courses. While a student's disclosure of his or her social security number here is not mandatory, any failure to provide this information may delay or otherwise impede the CDI in assigning credit for the completion of such courses to the appropriate students.

ALL ENTRIES MUST BE TYPED.

#	Social Security Number	Licensee Name: Last, First M.I.	Individual License #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Please use backside for additional names.

Certification

I have reviewed this Provider Roster and the associated Course Attendance Records or examination information and certify to the best of my knowledge that the individuals listed here meet the requirements for credit.

_____ (__)_____
Original signature of Provider Director Date Phone

_____
Printed Name of Provider Director

PROVIDER ROSTER (continued)

All entries must be typed.

#	Social Security Number	Licensee Name: Last, First M.I.	Individual License #
13.			
14.			
15.			
16.			
17.			
18			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			
33.			
34.			
35.			
36.			
37.			
38.			
39.			
40.			
41.			
42.			

43.

44.

45.

46.

47.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.4 and 10234.93(a)(4), Insurance Code.

HISTORY

1. New section filed 5–25–2006; operative 6–24–2006 (Register 2006, No. 21).

§ 2188.9. Rescission of Provider Certification or Course Approval.

(a) The approval of a course may be rescinded by the Commissioner pursuant to Insurance Code Section 1749.1(c) if it is determined that course content has been significantly changed without notice to the Insurance Commissioner and the change affects the number of hours assigned to the course, or the change in content would make the course ineligible for approval.

(b) Provider certification may be rescinded by the Commissioner if it is determined that:

(1) A certificate of completion is or has been issued to any individual who is or was not entitled to the issuance of any such certificate;

(2) A certificate of completion was not provided when requested by any student successfully completing the course;

(3) Any of the grounds exist on which the Commissioner may deny a provider certification;

(4) The provider has not complied with these regulations or applicable provisions of the California Insurance Code;

(5) The provider has failed to exercise reasonable care in evaluating the competency, good character, and integrity of any of its instructors; or

(6) The provider has allowed any other person or entity to use the provider's approved provider status or course approval status.

(c) Reinstatement of a rescinded certification or approval shall be at the discretion of the Commissioner after receipt of satisfactory proof that any conditions responsible for the rescission have been corrected, and the Insurance Commissioner has received an application for course approval pursuant to Section 2188.2 above, or an application for provider certification pursuant to Section 2188 above.

NOTE: Authority cited: Section 1749.7, Insurance Code. Reference: Sections 1749, 1749.1, 1749.3 and 1749.4, Insurance Code.

HISTORY

1. New section filed 8–23–96; operative 9–22–96 (Register 96, No. 34).

Article 6.8. Broker Fees

§ 2189.1. Applicability.

(a) The provisions of this article apply to all transactions and services performed by fire and casualty broker–agents acting in the capacity of an insurance broker for applicants, policyholders, or other consumers of an insurance coverage described in Insurance Code sections 660 or 675.

(b) Subdivisions 2189.3(a), (d), (e) and (g), 2189.4, and 2189.5(a), (b), (c), and (f) of this article shall not apply to a wholesale intermediary who in the particular transaction did not negotiate directly with the consumer, *provided that the wholesale intermediary discloses its fees in writing to* the retail broker–agent.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02 and 709.03(b), Insurance Code.

HISTORY

1. New article 6.8 (sections 2189.1–2189.8) and section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.2. Definitions.

(a) "Broker fee" means and includes any fee, however labeled, charged by an insurance broker, as defined in Insurance Code sections 33 and 1623, to provide services that constitute or arise out of the transaction of insurance, as defined in sections 35 of the Insurance Code, but excludes fees charged for services not constituting or arising out of the transaction of insurance.

(b) "Consumer" means an applicant or purchaser of personal insurance coverage described in Insurance Code sections 660 or 675.

(c) "Retail broker–agent" means a broker–agent that negotiates an insurance contract directly with a consumer.

(d) "Wholesale intermediary" means a broker–agent that negotiates an insurance contract with a retail broker–agent, but not with a consumer.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02 and 709.03(b), Insurance Code.

HISTORY

1. New section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.3. Broker Fee Requirements.

A broker–agent acting in the capacity of a broker may charge a broker fee, provided that:

(a) The consumer agrees to the fee in advance of the agreement required by subdivision 2189.3(e), after full disclosure of all material facts surrounding the fee, including if true the fact that an insurer may pay to the broker a commission in addition to the broker fee.

(b) The fee is not being charged directly or indirectly for services related to procuring coverage from the California Automobile Assigned Risk Plan or the California FAIR Plan, and is not prohibited by statute or regulation.

(c) The broker is not an appointed agent of the insurer with which the coverage is or will be placed.

(d) The broker provides the consumer with the Standard Broker Fee Disclosure set forth as Appendix A to this Article.

(e) The consumer and broker sign a broker fee agreement that includes at minimum, and does not conflict with, the Standard Broker Fee Agreement set forth as Appendix B to this Article.

(f) The broker has an in–force broker bond on file with the Department as required by Insurance Code sections 1662, 1663, and 1665.

(g) The broker discloses, concurrent with the conveyance of an initial premium quotation, the fact that a broker fee may be charged.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02, 709.03(b) and 790.06, Insurance Code.

HISTORY

1. New section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.4. Disclosure and Agreement.

The disclosure and agreement required by subdivisions 2189.3(d) and (e) shall be printed in English and in any other language principally used by the broker to advertise, solicit or negotiate the sale and purchase of insurance. The disclosure and agreement, signed or initialed by the consumer, shall be retained by a broker for eighteen months following the latest expiration of any policy to which the disclosure and agreement apply.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02 and 709.03(b), Insurance Code.

HISTORY

1. New section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.5. Unfair and Deceptive Acts and Practices.

The following acts shall be deemed unfair or deceptive when committed by a broker who has charged or will charge a broker fee:

(a) Failing to provide the consumer with the Standard Broker Fee Disclosure required by subdivision 2189.3(d).

(b) Failing to complete all relevant portions of the broker fee agreement required by subdivision 2189.3(e) before giving the agreement to the consumer for review.

(c) Failing to provide to a consumer a fully completed copy of the broker fee agreement required by subdivision 2189.3(e), signed by both the consumer and the broker, as soon as reasonably practicable.

(d) Failing promptly to refund an entire broker fee if the broker acted incompetently or dishonestly resulting in financial loss to the consumer, or if the broker did any of the following regardless of financial loss:

(1) Negligently or intentionally misquoted the premium to the consumer, resulting in an uprate.

(2) Permitted an unlicensed employee to transact insurance for, or on behalf of, the consumer paying the fee, where the Insurance Code required that employee to be licensed.

(3) Failed to refund unearned premium as required by Insurance Code section 393(a), except where permitted by Insurance Code sections 393(b) or 1735.5.

(4) Negligently or intentionally failed to place the consumer's coverage within the time period indicated to the consumer or within a timely manner.

(5) Negligently or intentionally failed to remit a consumer's premium payment to an insurer or general agent, resulting in policy cancellation.

(6) Failed to disclose the existence of the insurer's periodic payment plan, if one was available.

(7) Failed to refund unearned commission in the broker's possession to the person to whom it is owed within 30 days of the unearned commission being generated due to amendment or cessation of coverage.

(8) Failed to remit or apply to another policy premium finance company credit owed to the consumer/borrower within 15 days or receiving the credit from the premium finance company.

(e) Failing to place a consumer with an insurer with which the broker is appointed as an agent, solely for the purpose of charging a broker fee.

(f) Charging or attempting to charge a broker fee for a renewal, endorsement, or other service, that was not disclosed under section 6 of the Standard Broker Fee Agreement.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02, 709.03(b) and 790.06, Insurance Code.

HISTORY

1. New section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.6. Discipline.

(a) The failure to comply with any subdivision of this article by a fire and casualty broker–agent shall constitute a violation of Insurance Code section 1668(j), and shall be grounds to suspend or revoke a license pursuant to Insurance Code section 1738 et seq.

(b) Nothing contained within this article shall be deemed to limit the Commissioner's authority to impose disciplinary sanctions authorized by statute or regulation for conduct or nonfeasance by a broker not specifically addressed in this article.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.08 and 790.09, Insurance Code.

HISTORY

1. New section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.7. Severability.

If any provision of this article is invalidated by a court with proper jurisdiction, the remaining provisions shall continue in effect.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02, 709.03(b), 790.06, 790.08 and 790.09, Insurance Code.

HISTORY

1. New section filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

§ 2189.8. Effective Date.

This Article shall become effective on November 23, 2000.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Sections 790, 790.01, 790.02, 709.03(b), 790.08 and 790.09, Insurance Code.

HISTORY

1. New section and appendices A and B filed 8–25–2000; operative 11–23–2000 pursuant to Government Code section 11343.4(c) (Register 2000, No. 34).

Appendix A

STANDARD BROKER FEE DISCLOSURE

This disclosure was prepared by the California Insurance Commissioner. Please READ IT CAREFULLY!

I. Do not sign any broker fee agreement unless all of its blank lines and spaces have been filled–in and you have read this entire document and the agreement carefully.

II. Your insurance broker represents you, the consumer, and is entitled to charge a broker fee if he/she chooses. This fee is not set by law, and may be negotiable between you and the broker.

III. It is illegal or improper for an insurance broker to charge you a fee for placing coverage solely with the California Automobile Assigned Risk Plan or the California FAIR Plan. Fees may be charged for placement of other coverages.

IV. Broker fees are often non–refundable even if you cancel your coverage. Refer to your broker fee agreement to see if your broker fee is non–refundable. However, you may be entitled to a full refund of a broker fee if your broker acted incompetently or dishonestly. Unresolved disputes over non–refunded broker fees can be forwarded to the Department of Insurance for review.

V. You are entitled to obtain and keep a completed copy of this disclosure and any broker fee agreement you sign.

VI. Your broker may receive commission from insurance company(ies) for placing your insurance. This commission may be paid to your broker by the insurance company(ies) in addition to any broker fee you pay.

VII. If you will be paying your premium in installments to a finance company, by law you must receive a copy of a premium finance disclosure and agreement. Be sure to obtain and read those documents before signing a premium finance agreement. Also, ask the broker if the insurer offers its own installment payment plan. Insurer installment plans are often cheaper than premium financing through a separate premium finance company.

VIII. If your broker is placing automobile coverage, your broker must provide you with a copy of the current Department of Insurance pamphlet *Automobile Insurance*. If your broker is placing residential coverage, your broker must provide you with a copy of the current Department of Insurance pamphlet *Residential Insurance*. By signing the disclosure you acknowledge receipt of the appropriate pamphlet(s).

Client initials: _____

#10223 v1 – BROKER FEE REGS – DISCLOSURE FORM AS OF 3–21–00
March 22, 2000

Appendix B

STANDARD BROKER FEE AGREEMENT

1. The parties to this agreement are _____ ("CLIENT") and _____, California Department of Insurance license #XXXXXXX, ("BROKER").

2. CLIENT appoints BROKER as CLIENT'S insurance broker of record.

3. This agreement shall become operative on _____ (date), and shall continue in full force until terminated by either party.

4. BROKER agrees to represent CLIENT honestly and competently.

5. CLIENT agrees to pay BROKER a broker fee for BROKER'S services. The broker fee is $_____. The broker fee IS / IS NOT refundable (circle one).

6. BROKER may in the future charge CLIENT, and CLIENT agrees to pay, additional fee(s) for the services listed below. The additional fees and services are:

Service	Amount

7. Following are the nature and amount of all fees known to BROKER that will be charged by persons other than BROKER or the insurance company in connection with current placement of CLIENT's insurance. These fees are not retained by BROKER.

Service	Amount

_____

Client signature Date

_____

Broker signature Date

In case of any questions or problems concerning broker fees or insurance, contact the Department of Insurance at 1–(800) 927–HELP.

#10222 v1 – BROKER FEE REGS – AGREEMENT FORM AS OF 3–21–00
March 22, 2000

Article 7. Production Agency Records

§ 2190. Authority.

These regulations are promulgated pursuant to the authority granted the Commissioner under the provisions of Sections 1727, 1763 and 1768, of the Insurance Code. They shall apply to every agent or broker or surplus line broker or special lines' surplus lines broker licensed by the Commissioner. Surplus lines brokers and special lines' surplus lines brokers shall be subject to these regulations to the same extent and in the same manner as agents and brokers.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1727, 1763 and 1768, Insurance Code.

HISTORY

1. New Article 7 (Sections 2190–2190.8) filed 12–30–76; effective thirtieth day thereafter (Register 77, No. 1).
2. Amendment of section and NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.05. Definitions.

(a) The term "agent," as used in these regulations, means an insurance agent as defined in Insurance Code Section 1621.

(b) The term "broker" means an insurance broker as defined in Insurance Code Section 1623.

(c) The term "copy" as used in these regulations means any reproduction by which a reasonably clear image of the form, report or statement is provided, including the image of the executing broker's signature, including but not limited to a photocopy, facsimile transmission copy, and any other electronically transmitted digital reproduction.

(d) The term "secondary office" means an office of a resident agent or broker or surplus lines broker or special lines' surplus lines broker other than the principal office.

(e) The term "special lines' surplus lines broker" means a person licensed under Insurance Code Section 1760.5 and authorized to do business pursuant to Division 1, Part 2, Chapter 6 Sections 1760.5 through 1780.

(f) The term "surplus line broker" means a person licensed under Insurance Code Section 1765 and authorized to do business pursuant to Division 1, Part 2, Chapter 6 Sections 1760 through 1780.

(g) The term "resident surplus line broker" means a person licensed as a California resident under Insurance Code Section 1765 and authorized to do business pursuant to Division 1, Part 2, Chapter 6 Sections 1760 through 1780.

(h) The term "resident special lines' surplus lines broker" means a person licensed as a California resident under Insurance Code Section 1760.5 and authorized to do business pursuant to Division 1, Part 2, Chapter 6 Sections 1760.5 through 1780.

(i) The term "non–resident surplus line broker" means a person licensed as a resident surplus line broker in a state or territory of the United States other than California and who is licensed as a non–resident in California under Insurance Code Section 1765 and authorized to do business pursuant to Division 1, Part 2, Chapter 6 Sections 1760 through 1780.

(j) The term "non–resident special lines' surplus lines broker" means a person licensed as a resident special lines' surplus lines broker in a state or territory of the United States other than California, or the functional equivalent thereof offered by such state or territory, and who is licensed as a non–resident in California under Insurance Code Section 1760.5 and authorized to do business pursuant to Division 1, Part 2, Chapter 6 Sections 1760.5 through 1780.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1621, 1623, 1639, 1727 and 1760–1780, Insurance Code.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Amendment of section and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).
3. New subsections (g)–(j) and amendment of NOTE filed 7–14–2003 as an emergency; operative 7–14–2003 (Register 2003, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–12–2003 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–14–2003 order transmitted to OAL 11–5–2003 and filed 12–22–2003 (Register 2003, No. 52).

§ 2190.1. General.

(a) All record–keeping systems, whether manual or mechanical, must provide an audit trail so that details underlying the summary data, such as invoices, checks, and statements, may be identified and made available on request. All such systems must provide the means to trace any transaction back to its original source or forward to final entry, such as is accomplished by a conventional double–entry bookkeeping system. When automatic data processing systems are used, a description of the system must be available for review by the Department.

This description must contain statements and illustrations sufficiently detailed to indicate the application or process being performed, the procedures employed in each application or process (such as flow charts, block diagrams or other satisfactory descriptions of input or output procedures) and the controls used to insure accurate an reliable processing.

(b) All record–keeping systems, including automatic data processing systems and computer output microfilms, must be designed and programmed to produce the required information in an intelligible form. Identification of coding systems shall be readily available whenever they are used to record and maintain any of the information required under Sections 2190.2, 2190.3 and 2190.4.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1727, 1763 and 1768, Insurance Code.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. New NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.2. Required Records.

Wherever applicable, the following records shall be maintained by every agent or broker or surplus lines broker or special lines' surplus lines broker with respect to each and every insurance transaction for at least five years after expiration or cancellation date of the policy to which the records pertain:

(a) Name of insured,

(b) Name of insurer,

(c) Policy number,

(d) Effective date, termination date and mid–term cancellation date of coverage,

(e) Amount of gross premium,

(f) Amount of net premium,

(g) Amount of commission and basis on which computed,

(h) Names of persons who receive, or are promised, any commissions or other valuable consideration related to the transaction,

(i) Amount of premium received including itemization of any partial payments or additional premium,

(j) Date premium received by agent or broker,

(k) Date deposited in bank account or bank depository into which premiums are deposited or maintained in accord with Section 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code,

(*l*) Name and address of bank and number of account in which premium is deposited or maintained in accord with Section 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code,

(m) Date premium paid by agent or broker to the person entitled thereto and identification of the means of transmittal,

(n) Amount of net and gross return premium,

(o) Date return premium is received from insurer by agent or broker which may be the date the credit is taken from the insurer or the date the check or draft is received, and

(p) Date gross return premium is remitted to person entitled thereto by agent or broker and identification of means of transmittal.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1727, 1733, 1734, 1763 and 1768, Insurance Code.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Amendment of first paragraph, amendment of subsections (k) and (*l*) and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.3. Records by File.

(a) Wherever applicable, the following records shall be maintained by every agent or broker and surplus lines broker and special lines' surplus lines broker in a file pertaining to a particular insured for a period of eighteen months after the transaction described by such records:

(1) Identity of each person who transacted the insurance, renewals and any change in coverage,

(2) Records of all binders, whether written or oral, showing the names of insured and insurer, nature of coverage, effective and termination dates and premium for binder or policy to be issued,

(3) Copy of application or memorandum of request for insurance,

(4) Correspondence received, copies of correspondence sent, memoranda, notes of conversation, or any other record necessary to describe the transaction.

(b) The following records of surplus line transactions shall be maintained by every agent and broker and surplus lines broker and special lines' surplus lines broker for a period of at least five years after expiration or cancellation date of the policy to which the records pertain: forms, reports or statements required to be maintained or filed under Sections 1763 and 1764.1 of the Insurance Code.

(c) The agent, broker, surplus line broker or special lines' surplus lines broker who signs the form, report or statement under Insurance Code Section 1763 shall maintain the original. The agent, broker, surplus lines broker or special lines' surplus lines broker who receives the originally signed disclosure statement under Insurance Code Section 1764.1 shall maintain the original.

(d) The agent, broker, surplus line broker or special lines' surplus lines broker who signs the diligent search form under Insurance Code Section 1763 or receives the originally signed disclosure statement under Insurance Code Section 1764.1 shall send copies to all other agents, brokers, surplus lines brokers or special lines' surplus lines brokers involved in the transaction.

(e) The agent, broker, surplus line broker or special lines' surplus lines broker who receives copies of documents pursuant to 2190.3(d), shall maintain the copies which show the signature of the agent, broker, surplus lines broker, special lines' surplus lines broker or applicant who signed it.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1760.5(b), 1763 and 1764.1, Insurance Code.

HISTORY

1. Amendment of subsection (a) filed 6–27–78; designated effective 9–1–78(Register 78, No. 26).
2. Amendment of section and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.4. Direct Billing.

(a) With respect to any business transacted on a direct billing basis, the following records may be maintained in lieu of the records required by Section 2190.2:

(1) A policy record card or sheet or declaration page,

(2) Copies of premium payment receipts or other memoranda thereof for premiums collected when collected by the agent or broker,

(3) Records of premium payments made by the agent or broker,

(4) Copies of memoranda of any additional or return premium received by the agent or broker,

(5) Monthly or other periodic statements from the insurer showing premium receipts on the agent's or broker's business, and

(6) Copy of any cancellation notice, or letter of cancellation notice, or letter of cancellation for cause.

(b) All records specified in Section 2190.4(a)(1), (a)(2), (a)(3), (a)(4) and (a)(6) shall be maintained for at least five years after expiration or cancellation date of the policy.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1727, 1763 and 1768, Insurance Code.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Amendment of section and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.5. Bank Records.

(a) The following bank records shall be maintained at all times:

(1) Periodic statements of account supplied by the bank for all accounts or depositories into which premiums are deposited or maintained in accord with 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code.

(2) Records of all deposits made into such accounts or depositories into which premiums are deposited or maintained in accord with Section 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code.

(3) Cancelled checks drawn on, or records of withdrawal of funds from, such accounts or depositories into which premiums are deposited or maintained in accord with Section 1733 of the Insurance Code, including but not limited to trustee accounts maintained pursuant to Section 1734 of the Insurance Code.

(b) Nothing in this section is intended to abrogate the provisions of Insurance Code Section 1734 and 1734.5.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1733, 1734 and 1734.5, Insurance Code.

HISTORY

1. Renumbering from Section 2190.4 filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Amendment of section and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.6. Interest Bearing Accounts.

Whenever a principal has authorized an agent or broker or surplus lines broker or special lines' surplus lines broker to maintain funds received in a fiduciary capacity, as defined in Sections 1733 and 1734 of the Insurance Code, in an interest bearing account and to retain interest earned (i.e., savings account or certificate of deposit), such authorization shall be in writing and the original thereof shall at all times be maintained as part of the pertinent records of the agent or broker and shall be readily available on request, for so long as fiduciary funds are so maintained for such insurer.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1733 and 1734, Insurance Code.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Amendment of section and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2190.7. Place Where Records Kept.

(a) All records described in Sections 2190.2, 2190.4, 2190.5 and 2190.6 shall be kept in the principal office in this State of the resident agent or broker or resident surplus lines broker or resident special lines' surplus lines broker except where otherwise specifically authorized by the commissioner. All records described in Sections 2190.2, 2190.4, 2190.5 and 2190.6 for non–resident surplus line brokers and non–resident special lines' surplus lines brokers shall be kept in the principal office in the state or territory of the United States in which he or she is licensed as a resident surplus line broker or resident special lines' surplus lines broker.

(b) All records described by Section 2190.3 shall be maintained at the office servicing the insured.

(c) An agent operating under an exclusive contract with an insurer, including one insurer and its subsidiaries or affiliates, shall, upon termination of the appointment, be required to maintain only such records as such contract authorizes him to retain, provided that the insurer shall bear the

responsibility of maintaining within this State all other records which would have otherwise been required to be maintained by the agent, subject to the time limitations set forth in 2190.2, 2190.3 and 2190.4.

(d) All records shall be maintained in an orderly manner so that the information therein is readily available and shall be open to inspection or examination of the commissioner at all times and the commissioner may at any time require such licensee to furnish him any information maintained or required to be maintained.

(e) One year after cancellation or expiration of a policy, records pertaining thereto may be stored off premises so long as they are retrievable within two business days.

(f) An agent or broker may maintain the records, which are otherwise required by this article to be kept at the principal office, at a secondary office upon obtaining specific written authorization from the Insurance Commissioner, which authorization may impose any conditions or restrictions which the Insurance Commissioner deems to be necessary and proper.

NOTE: Authority cited: Sections 1727, 1763 and 1768, Insurance Code. Reference: Sections 1639, 1727, 1763, 1767 and 1768, Insurance Code.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Amendment of subsections (a) and (c) and new NOTE filed 8–28–98; operative 9–27–98 (Register 98, No. 35).
3. Amendment of subsection (a) and amendment of NOTE filed 7–14–2003 as an emergency; operative 7–14–2003 (Register 2003, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–12–2003 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–14–2003 order transmitted to OAL 11–5–2003 and filed 12–22–2003 (Register 2003, No. 52).

§ 2190.8. Retention Period.

HISTORY

1. Amendment filed 6–27–78; designated effective 9–1–78 (Register 78, No. 26).
2. Repealer filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

Article 7.5. Prescribed Method of Filing Notice of Appointment of Agents and Notice of Termination of Appointment of Agents

§ 2190.20. Authority and Purpose.

These regulations are promulgated pursuant to the authority granted the Commissioner under the provisions of Sections 1707 of the California Insurance Code. Except as otherwise provided in Section 1704.5, each notice of appointment or notice of termination of appointment shall be filed on forms prescribed by the commissioner within 10 days of appointment or termination.

NOTE: Authority cited: Section 1707, Insurance Code. Reference: Sections 1705 and 1707.5, Insurance Code.

HISTORY

1. New article 7.5 (sections 2190.20–2190.24) and section filed 7–12–2006; operative 8–11–2006 (Register 2006, No. 28).

§ 2190.22. Prescribed Method of Electronic Filing.

Within six months of the effective date of these regulations, all insurance companies, unless excepted by section 2190.24, are required to submit appointments and terminations in an electronic form for the following license lines: Fire & Casualty, Life Agent, Travel Agent, Disability Only, Part Time Fraternal, Motor Club, Personal Lines, and Home Protections. Additional lines of authority may be added to this section as technological advancement will allow. Any paper appointments or terminations received after the six month grace period will be considered null and void.

Electronic submission into the department's Insurance Producer Licensing Database shall be through any of the following approved entities:

(a) The National Insurance Producer Registry (NIPR) and its authorized business partners. NIPR is a subsidiary of the National Association of Insurance Commissioners (NAIC) and offers organizations the option of programming their own portal into NIPR or the option of using the portals provided by its authorized business partners. NIPR Authorized business partners may also be added or removed as new business partner agreements are made.

(b) Any additional vendors authorized by the California Department of Insurance to provide similar electronic submission services will be identified on the Department's official web site (www.insurance.ca.gov) as they become available. These regulations do not endorse any particular vendor.

(c) The California Department of Insurance also reserves the right to develop its own direct method of electronic submission of appointment and termination of company appointments.

NOTE: Authority cited: Section 1707, Insurance Code. Reference: Sections 1705 and 1707.5, Insurance Code.

HISTORY

1. New section filed 7–12–2006; operative 8–11–2006 (Register 2006, No. 28).

§ 2190.24. Prescribed Alternate Methods of Filing.

(a) An exception to the electronic submission requirement for company appointments and terminations for the lines of authority specified under section 2190.22 is made for companies that annually appoint and terminate, in the aggregate, 25 or fewer agents. Requests for exceptions to this requirement must be submitted in writing with an Action Notice of Appointment (Form LIC 447–54A, (Rev. 3/2006)) or Action Notice of Termination (Form LIC 447–54T, (Rev. 6/2006)) with applicable fees.

(b) An exception to the electronic submission requirement for company appointments and terminations is also made for lines of authority not covered under section 2190.22. In those cases, the insurer shall continue to submit in writing both the applicable forms and fees.

NOTE: Authority cited: Section 1707, Insurance Code. Reference: Sections 1705 and 1707.5, Insurance Code.

HISTORY

1. New section and new forms LIC 447–54A and LIC 447–54T filed 7–12–2006; operative 8–11–2006 (Register 2006, No. 28).

State of California Department of Insurance

Action Notice of Appointment

Form LIC 447-54A (Rev. 3/2006)

Pursuant to Sections 1704 through 1707 and/or 1673 or 1756 of the Insurance Code

Insurer Name: _____

FEIN: _____ NAIC # _____ CA Company # _____
Federal Employer Identification Number

To the Insurance Commissioner of the State of California: Notice is hereby given that effective from the date shown on this notice, the designated insurer hereby appoints the person(s) named herein to act as its agent.

When using this form with an Individual Application (441-9) or a Non-Resident Individual Application, please submit only one name per form and attach the form to the application.

*Appoint Type: FX: Fire and Casualty LX: Life LI: Life - Limited to pre-need (must submit Certificate of Exemption form 427-10)
TA: Travel DO: Disability Only PF: Part Time Fraternal MC: Motor Club
PL: Personal Lines HP: Home Protection

NOTE: Only one appointment type per line.

	Appoint Type *	Social Security/ FEIN	License #	Name: As shown on license	Effective date
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Signature of insurer: Signature must be that of an officer of the Company or a person authorized under a Special Power of Attorney on file with the Department.

Name Official Title Date

Phone Number ( )

Filing fees: Submit $24 per appointment type. Enter number of appointments [ ] $24 = [$]

1. If you are submitting only an action notice **Mail Action Notice and fee to:**

California Department of Insurance
P. O. Box 928
Sacramento, Ca 95812-0928

OR

2. If Action Notice is being submitted with original application
Mail Action Notice with Application and fee to:

California Department of Insurance
P. O. Box 1139
Sacramento, Ca 95812-1139

Receipt Code: 8160

Consumer Hotline (800) 927-HELP • Producer Licensing (800) 967-9331

State of California Department of Insurance

Action Notice of Termination

Form LIC 447-54T (Rev. 6/2006)

Pursuant to Sections 1704 through 1707 and/or 1673 or 1756 of the Insurance Code

Insurer Name: _____

FEIN: _____ NAIC # _____ CA Company # _____
Federal Employer Identification Number

To the Insurance Commissioner of the State of California: Notice is hereby given that effective from the date shown on this notice, the designated insurer hereby terminates the appointment of the licensee(s) named herein.

*Appoint Type: FX: Fire and Casualty LX: Life LI: Life - Limited to pre-need PL: Personal Lines
TA: Travel DO: Disability Only PF: Part Time Fraternal MC: Motor Club HP: Home Protection

NOTE: Only one appointment type per line.

	Appoint Type *	Social Security/ FEIN	License #	Name: As shown on license	Effective date
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

If you are terminating an appointment because you have reason to believe the agent may have violated the California Insurance Code, please attach signed statement.

Signature of insurer: Signature must be that of an officer of the Company or a person authorized under a Special Power of Attorney on file with the Department.

Name Official Title Date

Phone Number (___) _____

Filing fees: Submit $24 per termination type.

Enter number of terminations [ ] X $24 = [$]

Mail Action Notice of Termination and fee to:
California Department of Insurance
P.O. Box 928
Sacramento, CA 95812-0928

Receipt Code: 8160

Consumer Hotline (800) 927-HELP • Producer Licensing (800) 967-9331

[The next page is 527.]

Article 8. Insured Automobile Inspection

§ 2191. Insured Automobile Inspection. [Repealed]

NOTE: Authority cited: Sections 400, 401, 402, 403 and 12926, Insurance Code, Code. Reference: Sections 400, 402 and 403, Insurance Code.

HISTORY

1. New section filed 3–17–92; operative 4–1–92 (Register 92, No. 14).
2. Change without regulatory effect amending subsections (b), (b)(3), (c)(1), and form and repealer of subsection (d) and relettering filed 4–7–92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 19).
3. Change without regulatory effect repealing section filed 7–10–2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 28).

§ 2191.2. Automobile Theft and Loss Reporting.

(a) Purpose.

This section implements and interprets Insurance Code Section 1874.6.

(b) Automobile Theft and Loss Reporting.

All insurers issuing private passenger automobile insurance in California shall report, either directly or through an authorized representative, to the National Insurance Crime Bureau (NICB), formerly the National Automobile Theft Bureau, all private passenger automobiles involving in total losses as follows:

1. All total thefts of a private passenger automobile, having a wholesale value in excess of $2000.00, shall be reported within five (5) working days from the receipt of sufficient information from the insured.

2. All total losses involving private passenger automobile salvage where the vehicle is of the current model year or the four immediately preceding model years, however sustained, including claimant, shall be reported to the NICB within five (5) working days after he sale of salvage; or, if the insured, or third party claimant, is permitted to retain salvage, within five (5) working days after the date of loss payment.

3. The information reported to the NICB shall include the vehicle's Vehicle Identification Number (VIN), the vehicle's make, model, model year and any other information, as required by the NICB. Where possible, this information shall be obtained from the Automobile Inspection Report completed pursuant to Section 2191 of this Article.

(c) Theft Loss Verification Procedures.

Notwithstanding any provision of the Unfair Practices Act (Insurance Code Sections 790 et seq.) and Regulations to the contrary:

1. No insurer shall pay a claim filed by an insured, or a third party claimant, under comprehensive or other coverage for the total theft of a private passenger automobile with a wholesale market value in excess of $2000.00, unless the claim has first been reported to and either acknowledged by the NICB or no information indicating unresolved questionable circumstances about the claim has been received from the NICB within 10 working days from the date the insurer transmitted the report to the NICB.

2. Notwithstanding any provision of the Unfair Practices Act (Insurance Code Sections 790 et seq.) and Regulations to the contrary, an insurer may defer payment of a total theft loss claim filed under comprehensive or other coverage in accordance with the following:

(A) An insurer may defer the payment of such a claim for five (5) calendar days following receipt of an acknowledgement from the NICB of the Insurer's report. If no further communication is received from the NICB during this five (5) day period indicating unresolved questionable circumstances, the insurer shall continue with the processing of the claim in accordance with the provisions of this section and other provisions of the Unfair Practices Act (Insurance Code section 790 et seq.) and Regulations.

(B) If the NICB indicates in its acknowledgement or response to the insurer that coverage is in effect by more than one insurer for the same private passenger automobile or that the private passenger automobile has been previously reported as stolen and unrecovered, or that previous claims on the automobile have been reported, the insurer shall promptly investigate, attempt to resolve any discrepancy and report to the Fraud Division of the Department of Insurance, as required by Section 1872.4 of the Insurance Code.

(C) If the NICB discovers an erroneous vehicle identification number (VIN) and the NICB is unable to resolve the discrepancy internally, the NICB shall send a standardized inquiry to the insurer. A response to the inquiry shall be returned within five (5) working days by the insurer and the insurer shall notify the Fraud Division as required by Section 1872.4 of the Insurance Code. If the NICB and the insurer are unsuccessful, after due diligence in resolving the VIN error after a thirty–day (30–day) period from the date of the receipt by the insurer of sufficient information from the insured, the insurer shall proceed with the final processing of the claim.

(D) If the NICB indicates in its response to the insurer its belief, or if the insurer believes, that a fraudulent claim is being made by any claimant, the insurer shall report this information to the Fraud Division of the Department of Insurance as required by Section 1872.4 of the Insurance Code, suspend the processing of the claim and promptly begin an investigation. The insurer shall promptly provide such information to the NICB and shall cooperate fully with the NICB and the Department of Insurance in any investigation of potentially criminal or fraudulent acts.

(d) Definitions.

1. As used in this section, "private passenger automobile" means a motor vehicle of the private passenger or station wagon type, any four–wheel vehicle with a load capacity of 1,500 pounds or less, or a motorcycle.

2. As used in this section, and as provided in Section 544 of the Vehicle Code, "total salvage loss" means a private passenger automobile which has been wrecked, destroyed, or damaged, to such an extent that the owner, leasing company, financial institution, or the insurance company which has insured the vehicle, considers it uneconomical to repair the vehicle and because of this, the vehicle is not repaired by or for the person who owned the vehicle at the time of the event resulting in the damage.

3. As used in this section, "total theft" means the theft of a private passenger automobile.

NOTE: Authority cited: Section 1874.6, Insurance Code. Reference: Section 1874.6, Insurance Code.

HISTORY

1. New section filed 4–1–93; operative 5–1–93 (Register 93, No. 14).

Article 9. Credit Insurance Agent Licensing Regulations

§ 2192.1. Authority.

The Insurance Commissioner has promulgated this article pursuant to Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999).

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.9–1758.994, Insurance Code.

HISTORY

1. New article 9 (sections 2192.1–2192.13) and section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealer of article 9 (sections 2192.1–2192.13) and section by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New article 9 (sections 2192.1–2192.13) and section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New article 9 (sections 2192.1–2192.13) and section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealer of article 9 (sections 2192.1–2192.13) and repealer of section by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New article 9 (sections 2192.1–2192.13) and section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New article 9 (sections 2192.1–2192.13) and section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of

Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.

8. New article 9 (sections 2192.1–2192.12) and section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New article 9 (sections 2192.1–2192.12) and section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.2. Applicability.

This article applies to all credit insurance agents, all applicants for a credit insurance agent license, and all persons who transact credit insurance, whether licensed or not.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.9–1758.994, Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.3. Definitions.

The following definitions apply to these regulations and to Article 16.7 of Chapter 5 of Part 2 of Division 1 of the Insurance Code (commencing with Section 1758.9):

(a) "Authorized insurer" means an insurance company holding a certificate of authority from the California Insurance Commissioner, and that is permitted by that certificate of authority to transact the kinds of insurance enumerated in Insurance Code section 1758.96.

(b) "Sell" has the same meaning as "enrollment," as that term is defined in Insurance Code section 1758.992(a).

(c) "Solicit" means to mention the availability of credit insurance to a current or prospective debtor, to recommend or suggest consideration of credit insurance to a current or prospective debtor, or to ask a current or prospective debtor if he or she might be interested in obtaining credit insurance.

(d) "Endorsee" means a natural person who is authorized by the Commissioner to sell or solicit credit insurance and is employed by a credit insurance agent organization.

(e) "Commission" means any tangible or intangible thing of value, the existence, size, quality or quantity of which depends on the quantity or value of credit insurance solicited, sold, or enrolled by the person receiving the commission. "Commission" does not include salary paid to an employee of a creditor who sells, solicits, or enrolls, as long as the amount of the salary does not depend on the quantity or value of credit insurance solicited, sold, or enrolled by the employee.

(f) "Compensation," as that term is used in Insurance Code section 1758.98(c), has the same meaning as "commission."

(g) "Fee," for the purpose of section 1758.98(c), shall have the same meaning as "commission."

(h) "Material terms and conditions," as that phrase is used in Insurance Code section 1758.97(a)(1), means all terms and conditions that, if known by or communicated to a sophisticated, prospective purchaser of credit insurance, would more likely than not influence that purchaser's decision to buy or not buy the insurance on the stated terms.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1634(h), 1758.9, 1758.91, 1758.92(a)(2), 1758.92(b), 1758.93, 1758.93(b), 1758.94(a), 1758.94(b), 1758.95(a), 1758.95(b), 1758.95(c), 1758.96, 1758.97, 1758.97(b)(3), 1758.97(e), 1758.98(a), 1757.98(b), 1757.98(c) and 1758.992(a), Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.4. Applications; License Term.

(a) A separate license must be applied for and obtained by each natural person (i.e., individual) before that person acts as a credit insurance agent. A separate license must be applied for and obtained by each organization before that organization acts as a credit insurance agent.

(b) A natural person may sell, solicit, or otherwise transact credit insurance and receive a commission as a licensed credit insurance agent or as an endorsee of an organization that holds a credit insurance agent license. A natural person may be named simultaneously as an endorsee of multiple organizations that hold credit insurance agent licenses.

(c) A credit insurance agent license, whether issued to an individual or an organization, is valid for twelve months, and must be renewed annually by the anniversary of the issue date.

(d) An individual credit insurance agent license applicant must obtain electronic fingerprint impressions from the Department's vendor for that service, using the Request For Live Scan Service (Form 442–39A). The manager of each business location of an organization licensed as a credit insurance agent must obtain electronic fingerprint impressions from the Department's vendor for that service, using the Request For Live Scan Service (Form 442–39A).

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.9–1758.93, Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.5. Fees.

(a) A $300 fee must be paid at the time a credit insurance agent license application is filed with the Department. A $30 fee for each endorsee must accompany the organization endorsement appointment form.

(b) A $274 fee must be paid at the time a credit insurance agent license renewal application is filed with the Department. A $4 fee must be paid at the time an endorsee renewal application is filed with the Department.

(c) The Commissioner must refuse to issue a credit insurance agent license if the appropriate fees do not accompany the application.

(d) Subject to Insurance Code Sections 12978 and 1758.92(a)(3), the Commissioner may increase or decrease the fees set forth above to reflect the actual costs associated with processing the application and renewal transactions.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.92(a)(3) and 12978, Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.6. Disclosure.

(a) All disclosures required by Insurance Code sections 1758.97(a) and (b) must be printed and must be clear and conspicuous.

(b) An insurer must include in the evidence of coverage it provides to a purchaser, pursuant to Insurance Code section 1758.97(c), all provisions the insurer could rely upon to deny a claim. An insurer may not rely upon a policy provision to deny a claim unless that provision was included in the evidence of coverage.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.97(a)–(c), Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.7. Training.

(a) The training materials required by Insurance Code Section 1758.93(b) must be prepared and submitted to the Commissioner, and must include training for all insurance products to be sold.

(b) Retraining of endorsees must be conducted whenever there is a change in the insurance product(s) sold, but in no event less frequently than every two (2) years for each endorsee.

(c) If training materials have been developed by an insurer and approved by the Department of Insurance, the licensee may submit, in lieu of the training materials, a letter, signed by the licensee's manager or a corporate officer, stating that the licensee will use the approved training materials filed by the insurer.

[The next page is 528.2(c).]

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.93(a)(2), 1758.93(b) and (c) and 1758.94(a), Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.8. Records.

Credit insurance agents must comply with the provisions of Insurance Code section 1727 and Article 7 of Chapter 5 of Subchapter 1 of Title 10 of the California Code of Regulations, commencing with section 2190.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.9–1758.994, Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.9. Forms.

(a) The Commissioner requires credit insurance agent applicants and licensees to submit the following forms for the following purposes:

(1) The written application for licensure must be made using Form 441–9 (01–03) for individuals and using Form 441–11 (05–04) for organizations.

(2) The credit insurance agent notice of appointment must be made using Form LIC.CI 20 (05–01).

(3) The employee affidavit of training and knowledge must be made using Form LIC.CI 50 (05–01).

(4) The annual certificate of compliance and listing for authorized endorsees must be made using Form LIC.CI 40 (05–01).

(5) The annual training material submission must be made using Form LIC.CI 10 (05–01).

(6) Fingerprint impressions must be requested, and their having been taken evidenced by completion and submission to the Department of a Request for Live Scan Service using Form 442–39A (04–04).

(7) Organization endorsements must be made using Form 411–8A (12–03).

(b) Training materials submitted to the Commissioner must contain all of the elements set forth in Form LIC.CI 30 (05–01).

(c) All forms set forth in this section are incorporated herein by reference in their entirety and are available upon request, by telephone or in writing, to the Department of Insurance, and on the Department of Insurance website, www.insurance.ca.gov.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.92(a)(1) and (2), Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order, including amendment of section, transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.10. Certifications.

Any certification required by Article 16.7 of Chapter 5 of Part 2 of Division 1 of the Insurance Code (commencing with Section 1758.9) must

be made under penalty of perjury under the laws of the State of California.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.92(a)(1) and (2) and 1758.93(a)(2), Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.11. Limitations on the Authority of the Credit Insurance Agent to Transact.

Pursuant to Insurance Code section 1758.96, a person licensed as a credit insurance agent may not sell credit insurance in connection with the loan in excess of $60,000 relating to or secured by real property, or where the repayment period for any loan or extension of credit exceeds 10 years.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Section 1758.96, Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.12. Endorsee Termination and Renewal.

The Department must provide an organization that holds a credit insurance agent license a list of its endorsees 90 days prior to the renewal of the organization's license. The organization must terminate endorsees no longer employed by the organization by striking through those endorsees' names, having an officer sign and date the list, and return the list to the Department along with the renewal fees for the non–stricken, active endorsees. The organization must return the endorsee list with an Annual Certificate of Training and List of Endorsee Form LIC.CI 40 to certify that the endorsees have received required training. The submission of the list to the Department will satisfy the credit insurance agent's duty to submit an annual listing of endorsees pursuant to Section 1758.93(b).

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.93(a)(3) and 1758.93(b), Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–3–2002 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. New section refiled 12–23–2003 as an emergency; operative 12–23–2003 (Register 2003, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–21–2004 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 18).
10. New section filed 4–29–2004 as an emergency; operative 4–29–2004 (Register 2004, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2004 order transmitted to OAL 6–25–2004 and filed 7–29–2004 (Register 2004, No. 31).

§ 2192.13. Effective Date.

NOTE: Authority cited: Statutes of 2000, Chapter 321, Section 8 (Assembly Bill No. 393, 1999). Reference: Sections 1758.9–1758.994, Insurance Code.

HISTORY

1. New section filed 9–17–2001 as an emergency; operative 9–17–2001 (Register 2001, No. 38). A Certificate of Compliance must be transmitted to OAL by 1–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2002, No. 5).
3. New section filed 1–31–2002 as an emergency; operative 2–1–2002 (Register 2002, No. 5). A Certificate of Compliance must be transmitted to OAL by

6–3–2002 or emergency language will be repealed by operation of law on the following day.

4. New section refiled 6–3–2002 as an emergency; operative 6–3–2002 (Register 2002, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–1–2002 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 10).
6. New section filed 4–29–2003 as an emergency; operative 4–29–2003 (Register 2003, No. 18). A Certificate of Compliance must be transmitted to OAL by 8–27–2003 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 8–26–2003 as an emergency; operative 8–26–2003 (Register 2003, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–24–2003 or emergency language will be repealed by operation of law on the following day.
8. Repealed by operation of Government Code section 11346.1(g) (Register 2003, No. 52).

Article 10. Clerical Activities Exempt from Licensure

§ 2193. Definitions.

For the purpose of this article, the following definitions apply:

(a) "Licensee" means a person that holds a valid license from the Commissioner authorizing that person to solicit, negotiate or effect contracts of insurance, or act in any of the capacities defined in Insurance Code Sections 1621 through 1624, as provided in Chapter 5 (commencing with Section 1621), Part 2, Division 1 of the Insurance Code.

(b) "Unlicensed person" means a person that does not hold a valid license from the Commissioner authorizing that person to solicit, negotiate or effect contracts of insurance, or act in any of the capacities defined in Insurance Code sections 1621 through 1624, as provided in Chapter 5 (commencing with Section 1621), Part 2, Division 1 of the Insurance Code.

NOTE: Authority cited: Section 8, Assembly Bill 393, Chapter 321, Statutes of 2000. Reference: Sections 1631 and 1635, Insurance Code.

HISTORY

1. New article 10 (sections 2193–2193.3) and section filed 6–17–2002 as an emergency; operative 6–17–2002 (Register 2002, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–17–2002 order transmitted to OAL 10–10–2002 and filed 11–7–2002 (Register 2002, No. 45).

§ 2193.1. Exemptions for Clerical Activities.

Clerical activities indirectly related to the solicitation, negotiation, or effecting the sale of insurance which, pursuant to Insurance Code Section 1635(*l*), are exempt from licensure, include, but are not limited to:

(a) Distribution of brochures, business cards, or other general information advertising insurance agencies or insurers, or insurance products, services or promotions, provided that unlicensed persons do not analyze, give advice or make recommendations concerning insurance contracts or potential insurance contract terms to applicants for insurance coverage, potential applications for insurance coverage, or policyholders.

(b) Preparation of applications for insurance coverage without any contact with applicants, other than the contact permitted in Section 2193.2(d).

(c) Obtaining underwriting information from third parties, including, but not limited to, the Department of Motor Vehicles, credit reporting agencies and other insurance companies.

(d) Preparation of binders, certificates, endorsements, identification cards, policies and similar evidences of insurance, under the supervision of licensees and for the review and signature of licensees, provided that the unlicensed persons are not signing such documents, either in their names or in the names of the licensees.

NOTE: Authority cited: Section 8, Assembly Bill 393, Chapter 321, Statutes of 2000. Reference: Sections 1631 and 1635, Insurance Code.

HISTORY

1. New section filed 6–17–2002 as an emergency; operative 6–17–2002 (Register 2002, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–17–2002 order transmitted to OAL 10–10–2002 and filed 11–7–2002 (Register 2002, No. 45).

§ 2193.2. Exemptions for Making Clerical Changes and Providing Indirect Marketing and Servicing Support.

Clerical activities involving the making of changes to existing insurance policies or providing indirect insurance marketing and servicing support which, pursuant to Insurance Code Section 1635(m), are exempt from licensure, include, but are not limited to:

(a) Dissemination of buyers' guides for insurance, applications for insurance coverage, insurance coverage selection forms, or related forms, in response to consumer requests, provided that unlicensed persons do not analyze, give advice or make recommendations concerning insurance contracts or potential insurance contract terms to applicants for insurance coverage, potential applicants for insurance coverage, or policyholders.

(b) Receiving information from applicants for insurance coverage, potential applicants for insurance coverage, or policyholders, or recording information from applicants for insurance coverage, potential applicants for insurance coverage, or policyholders to give to licensees for response, provided that the unlicensed persons do not analyze, give advice or make recommendations concerning insurance contracts or potential insurance contract terms to applicants for insurance coverage, potential applicants for insurance coverage, or policyholders.

(c) Scheduling appointments with licensees to discuss insurance, provided that there are no conversations, or other exchanges of information concerning insurance contracts or potential insurance contract terms between unlicensed persons and applicants for insurance coverage, potential applicants for insurance coverage, or policyholders.

(d) Communicating with applicants for insurance coverage, potential applicants for insurance coverage, or policyholders solely in order to obtain factual information requested by licensees, provided that unlicensed persons do not analyze, give advice or make recommendations concerning insurance contracts or potential insurance contract terms to applicants for insurance coverage, potential applicants for insurance coverage, or policyholders.

(e) Acceptance of insurance premiums for delivery to licensees.

(f) Receiving and recording insureds' requests for additions or deletions to existing insurance policies, and preparing endorsement forms for the review and signature of licensees.

(g) Informing insureds factually, in response to their inquiries, as to the category and financial limits of insurance coverages indicated in policy records, whether coverages are in effect and any premium balances due, provided that the unlicensed persons are not otherwise explaining, interpreting, or offering opinions on such coverages or limits, or any other terms of the insurance contracts.

(h) Answering telephone calls, receiving faxes, opening electronic mail, opening written mail, processing outgoing mail, doing filing, and engaging in other general secretarial or administrative functions not otherwise prohibited herein.

(i) Merely translating between licensees and applicant for insurance coverage, potential applicants for insurance coverage, or policyholders.

NOTE: Authority cited: Section 8, Assembly Bill 393, Chapter 321, Statutes of 2000. Reference: Sections 1631 and 1635, Insurance Code.

HISTORY

1. New section filed 6–17–2002 as an emergency; operative 6–17–2002 (Register 2002, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–17–2002 order transmitted to OAL 10–10–2002 and filed 11–7–2002 (Register 2002, No. 45).

§ 2193.3. Necessity of License.

The following activities are not exempt from licensure under Insurance Code Sections 1631 and 1635, because they are directly related to solicitation, negotiation, or effecting the sale of insurance:

(a) Explanations or interpretations of, and offering of opinions or recommendations on, insurance coverages, exposures, limits, premiums, rates, deductibles, payment plans, or any other insurance contract, or potential insurance contract, terms.

(b) Recommending, advising, or urging applicants for insurance coverage, potential applicants for insurance coverage, or policyholders to buy particular insurance policies or to insure with particular companies or insurers.

(c) Binding of insurance coverages.

NOTE: Authority cited: Section 8, Assembly Bill 393, Chapter 321, Statutes of 2000. Reference: Sections 1631 and 1635, Insurance Code.

HISTORY

1. New section filed 6–17–2002 as an emergency; operative 6–17–2002 (Register 2002, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–15–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–17–2002 order transmitted to OAL 10–10–2002 and filed 11–7–2002 (Register 2002, No. 45).

Article 11. Communications Equipment Agent Licensing Regulations

§ 2194. Authority and Purpose.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Assembly Bill No. 2856 (Stats. 2002, ch. 437). No communications equipment vendor may sell or offer insurance without complying with Sections 1758.6–1758.693 of the California Insurance Code. (For operative effect, see Insurance Code section 1758.693.)

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Sections 1758.6–1758.693, Insurance Code.

HISTORY

1. New article 11 (sections 2194–2194.8) and section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New article 11 (sections 2194–2194.8) and section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New article 11 (sections 2194–2194.8) and section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New article 11 (sections 2194–2194.8) and section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.1. Definitions.

As used in these regulations and in Article 16.1 (commencing with Section 1758.6) of the Insurance Code:

(a) "Insurer" means an insurance company holding a California certificate of authority.

(b) "Franchise" and its derivatives are as defined in the California Corporations Code, Title 4, Division 5, Part 1 (commencing with Section 31005).

(c) "Organization" means any legal entity other than a natural person. Where reference is made to a natural person named on an organization license, the reference shall be to a person who is named to exercise the power and perform the duties under an organization license. The natural person named on the organizational license shall meet the qualifications required for the type of license sought by the organization.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Sections 1628 and 1758.68, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.2. Applications.

(a) Each natural person (i.e., individual) or organization intending to act as a communications equipment insurance agent shall apply for and obtain a separate license.

(b) An individual or organization licensee shall file with the Commissioner any true name or fictitious name(s) under which the applicant intends to act as a communications equipment agent. The Commissioner may disapprove, in writing, the use of any true or fictitious name (other than the bona fide true name of the individual) by any licensee pursuant to Article 1 (commencing with section 2050) of this chapter.

(c) Any certification required in Article 16.1 (commencing with Section 1758.6) of the Insurance Code shall be made under penalty of perjury under the laws of the State of California.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Section 1758.62, Insurance Code; and Article 1 (commencing with section 2050), California Code of Regulations, Title 10.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.3. Fees.

(a) A fee of $225 shall be paid at the time the license application is filed.

(1) Applications that are not accompanied by the appropriate fee shall not be accepted for filing, whether or not they contain all the documents otherwise required by Sections 1758.62(a) and 1758.63(c) of the Insurance Code.

(b) A fee of $225 shall be paid at the time a communications equipment agent license renewal application is filed.

(c) Costs charged by the Department of Insurance for any enforcement action or investigation shall be paid by the licensee, in addition to the application or renewal filing fee.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Sections 1758.62 and 1758.692, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by

7–7–2004 or emergency language will be repealed by operation of law on the following day.

4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.4. Disclosure.

(a) The brochures or other materials that are provided to the prospective customer pursuant to Section 1758.66 of the Insurance Code shall include, among other information:

(1) the approved true or fictitious name under which the licensee is doing business at the location in which the communications equipment transaction is taking place; and

(2) the name of the insurer providing the insurance being offered to the prospective purchaser.

(b) All disclosures required by Section 1758.66 of the Insurance Code and these regulations shall be written clearly and conspicuously.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Section 1758.66, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.5. Training.

If the training materials required pursuant to Section 1758.63(c) of the Insurance Code have been previously approved by the California Department of Insurance, the applicant is not required to submit the training materials. The applicant instead shall submit a letter, signed by both the fire and casualty broker–agent and by the applicant (or officer of the entity), stating that the applicant will use the approved training materials filed by the fire and casualty broker–agent.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Section 1758.63, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.6. Records.

(a) Records of insurance transactions and other documents required by Article 16.1 (commencing with Section 1758.6) of the Insurance Code and these regulations shall be maintained for at least three (3) years after the expiration or cancellation date of the policy to which the records pertain, except where otherwise specifically authorized by statute or by the Commissioner in regulation.

(b) Records shall be kept in this State, in the principal office of the licensee, except where otherwise specifically authorized by statute or by the Commissioner in regulation.

(c) Records shall be produced for examination by the Commissioner or a designee of the Commissioner within thirty (30) days of the mailing date of a written request. Records may be requested in electronic or written format by the Commissioner or a designee of the Commissioner.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Section 1758.63, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.7. Forms.

The specific forms required to be filed with the Commissioner by license applicants and licensees are as follows:

(a) The written application for licensure shall be made on Form 441–9 (Rev 01/2003) for individuals and on Form 441–11 (Rev 01/2003) for organizations.

(b) The initial certification of authorized employees shall be made on form Lic. CV 1 (Rev 12/2002).

(c) The annual certification of authorized employees shall be made on form Lic. CV 2 (Rev 12/2002).

(d) The insurer certification shall be made on form Lic. CV 3 (Rev 9/2004).

(e) Training materials submitted to the Commissioner shall contain all of the elements set forth in form Lic. CV 4 (Rev 12/2002).

(f) The list of authorized endorsees shall be made on form Lic. CV 5 (Rev 9/2004). The list shall be maintained in a format capable of transmission to the Commissioner or a designee of the Commissioner electronically and in hard copy or diskette, however requested by the Commissioner or a designee of the Commissioner pursuant to Section 2194.6(c) above. The electronic version shall be transmitted in commercial word–processing or spreadsheet form. When requested, the list shall be updated to include endorsees newly authorized up to thirty (30) days before the mailing date of the request, and shall include the dates upon which each endorsee's authorization began and, if relevant, terminated. It shall then be transmitted as an attachment to e–mail or by regular mail in hard copy or diskette, as requested. The appropriate e–mail and regular mailing addresses shall be posted by the Department on its website at http://www.insurance.ca.gov.

(g) All forms set forth in this section are incorporated herein by reference in their entirety and are available upon request, by telephone or in writing, to the Department of Insurance or on the website of the Department of Insurance at www.insurance.ca.gov.

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Sections 1758.62 and 1758.63, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order, including amendment of subsections (d) and (f), transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

§ 2194.8. Procedures.

(a) The following criteria shall apply to procedures employed by the Commissioner in considering and issuing licenses under this article:

(1) If the application is deficient, the Commissioner shall, within twenty–one (21) days of receipt of the license application, inform the applicant, in writing, that the application is deficient and what specific information is required for completion. Absent notice of a deficiency, the application is deemed complete at the date of filing.

(2) The Commissioner shall, within thirty (30) calendar days of the applicant's filing of a completed application, reach a decision whether to issue or deny a license, and shall notify the applicant of the decision. If the Commissioner has decided to deny the application, the reason(s) therefor shall be set forth in the notification.

(b) The periods set forth above shall be tolled in the event the application requires legal action by the Commissioner.

(c) The Department of Insurance's median, minimum and maximum times for processing a similar license from the receipt of the initial completed application to the final license decision, and excluding applications that require legal action by the Commissioner, are as follows:

(1) thirty (30) calendar days (median time),

(2) fourteen (14) calendar days (minimum time), and

(3) one (1) calendar year (maximum time).

NOTE: Authority cited: Sections 1758.6 and 1758.693, Insurance Code. Reference: Section 15376, Government Code; and Section 1670, Insurance Code.

HISTORY

1. New section filed 7–11–2003 as an emergency; operative 7–11–2003 (Register 2003, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–10–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–7–2003 as an emergency; operative 11–10–2003 (Register 2003, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–9–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–8–2004 as an emergency; operative 3–9–2004 (Register 2004, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–7–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–7–2004 as an emergency; operative 7–7–2004 (Register 2004, No. 28). A Certificate of Compliance must be transmitted to OAL by 11–4–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–7–2004 order transmitted to OAL 11–2–2004 and filed 12–17–2004 (Register 2004, No. 51).

Article 12. Self–Service Storage Agent Licensing Regulations

§ 2194.9. Authority and Purpose.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Assembly Bill No. 2520 (Stats. 2004, ch. 428). No self–service storage facility may sell or offer insurance without complying with Sections 1758.7–1758.792 of the California Insurance Code and these regulations.

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Sections 1758.7–1758.792, Insurance Code.

HISTORY

1. New article 12 (sections 2194.9–2194.17) and section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.10. Definitions.

As used in these regulations and in Article 16.3 (commencing with Section 1758.7) of the Insurance Code:

(a) "Authorized insurer" means any admitted insurer holding a California Certificate of Authority that includes the kinds of insurance enumerated in Section 1758.75 of the Insurance Code.

(b) "Franchise" and its derivatives are as defined in the California Corporations Code, Title 4, Division 5, Part 1 (commencing with Section 31005).

(c) "Organization" means any legal entity other than a natural person. Where reference is made to a natural person named on an organization license, the reference shall be to a person who is named to exercise the power and perform the duties under an organization license.

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Sections 1628 and 1758.7, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.11. Applications.

(a) Each natural person (i.e., individual) or organization intending to act as a self–service storage insurance agent shall apply for and obtain a separate license.

(1) An individual licensee may own or act as the franchisee of more than one self–service storage company without obtaining additional licenses.

(2) An organization licensee may act as the franchisee of more than one self–service storage company without obtaining additional licenses.

(b) An individual or organization licensee shall file with the Commissioner any true name or fictitious name(s) under which the applicant intends to act as a self–service storage agent. The Commissioner may disapprove in writing, the use of any true or fictitious name (other than the bona fide true name of the individual) by any licensee pursuant to Article 1 (commencing with Section 2050) of this chapter.

(c) Any certification required in Article 16.3 (commencing with Section 1758.7) of the Insurance Code shall be made under penalty of perjury under the laws of the State of California.

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Sections 1758.71 and 1758.72, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.12. Fees.

(a) A fee of $250 shall be paid at the time the license application is filed.

(1) Applications that are not accompanied by the appropriate fee shall not be accepted for filing, whether or not they contain all the documents otherwise required by Sections 1758.71(a) and 1758.72(b) of the California Insurance Code.

(b) A fee of $250 shall be paid at the time of self–service storage agent license renewal application is filed.

(c) Costs charged by the Department of Insurance for any enforcement action or investigation shall be paid by the licensee, in addition to the application or renewal filing fee.

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Sections 1758.7 and 1758.71, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.13. Disclosure.

(a) The brochures or other materials that are provided to the prospective renter pursuant to Section 1758.76 of the California Insurance Code shall include, among other information:

(1) the approved true or fictitious name under which the licensee is doing business at the location in which the self–service storage transaction is taking place; and

(2) the name(s) of any insurer(s) providing the insurance being offered to the prospective purchaser.

(b) All disclosures required by Section 1758.76(b) of the California Insurance Code and these regulations shall be in writing and provided in a clear and conspicuous manner.

(c) A copy of the rental agreement shall be provided to the customer at the time of execution of the self–service storage rental agreement.

NOTE: Authority cited: Sections 1758.7, 1758.76(b), 1758.79 and 1758.792, Insurance Code. Reference: Sections 1758.75 and 1758.76, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.14. Training.

(a) If the training materials required pursuant to Section 1758.72(b) of the Insurance Code have been previously approved by the California Department of Insurance, the applicant is not required to submit the training materials. The applicant instead shall submit a letter, signed by both the fire and casualty broker–agent and by the applicant (or officer of the entity), stating that the applicant will use the approved training materials filed by the fire and casualty broker–agent.

(b) If endorsees of a single licensee doing business under the same name at multiple locations are selling the same insurance product, only one set of training materials need be submitted to the Commissioner for that product.

(c) Insurance products provided by different insurers shall be deemed to be different products for the purpose of these regulations.

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Section 1758.72, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.15. Records.

(a) Records of insurance transactions and other documents required by Article 16.3 (commencing with Section 1758.7) of the Insurance Code and these regulations shall be maintained for at least three (3) years after the expiration or cancellation date of the policy to which the records pertain, except where otherwise specifically authorized by statute or by the Commissioner in regulation.

(b) Records shall be kept in this State, in the principal office of the licensee, except where otherwise specifically authorized by statute or by the Commissioner in regulation.

(c) Records shall be produced for examination by the Commissioner or a designee of the Commissioner within thirty (30) days from the mailing date of a written request. Records may be requested in electronic or written format.

NOTE: Authority cited: Sections 1758.7, 1758.71, 1758.72 and 178.792, Insurance Code. Reference: Sections 1758.7, 1758.71 and 1758.72, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

§ 2194.16. Forms.

The following information is required to be filed with the Commissioner by license applicants and licensees:

(a) Form 441–9 for individuals.

For Department Use Only
License #_____
Passed Exam Date _____
Effective Date_____
WS #_____

State of California
Department of Insurance
Individual License Application
(Type or print clearly)

For Department Use Only		
Ready to Issue	YES	NO
Work Auth. Exp. Date	N/A	Date / /
Pending DBA Approval	NO	YES
Refer to LBB	NO	YES

Work Station Stamp

① **APPLICATION TYPE:** ☐ PERMANENT ☐ CERTIFICATE OF CONVENIENCE

② **LICENSE TYPE:**

- ☐ Life Agent (LX)
- ☐ Fire & Casualty Broker-Agent (FX)
- ☐ Personal Lines Broker-Agent (PL)
- ☐ Credit Insurance (CI)
- ☐ Part Time Fraternal (PF)
- ☐ Travel Agent (TA)
- ☐ Communications Equipment Agent(CV)
- ☐ Rental Car Agent (RC)
- ☐ Life & Disability Analyst (LA)
- ☐ Surplus Line Broker (SL)**
- ☐ Special Lines' Surplus Line Broker (SP)**
- ☐ Motor Club Agent (MC)
- ☐ Cargo Shipper's Agent (CS)
- ☐ Vehicle Service Contract Provider (VS)
- ☐ Self-Service Storage Agent (SS)

③ Social Security Number (SSN)*
___-___-____

④ Last Name | First Name | Full Middle Name | Suffix

⑤ ☐ Male ☐ Female

⑥ Date of Birth (month/day/year)

⑦ Resident Address (P.O. Box not acceptable)

⑧ City

⑨ State

⑩ Zip Code

⑪ Home Phone Number ( ) -

⑫ Are you a citizen of the United States? (check one) ☐ Yes ☐ No (If No, you must supply a copy of both sides of your work authorization)

⑬ Are you affiliated with a financial institution/bank? ☐ Yes ☐ No

⑭ Business Address (P.O. Box not acceptable.)

⑮ City

⑯ State

⑰ Zip Code

⑱ Business Phone Number ( ) -

⑲ Business Fax Number ( ) -

⑳ E-mail Address (required to self schedule)

㉑ Business Web Site Address

㉒ Mailing Address (P. O. Box is acceptable)

㉓ City .

㉔ State

㉕ Zip Code

(26)

SPECIAL ACCOMMODATION REQUEST FOR EXAMINATION
(In Compliance with The Americans with Disabilities Act)

Do you have a disability/impairment for which you may need assistance during the examination(s)? ☐ Yes ☐ No

If Yes, you are required to submit documentation from the medical authority or learning institution that rendered the diagnosis. Verification must be submitted, with the application on the letterhead of the authority or specialist, and include the following:

- Description of the disability and limitations related to the testing
- Recommended accommodation/modification
- Name, title, and telephone number of the medical authority or specialist
- Original Signature of the medical authority or specialist
- Professional license or certification number of the medical authority or specialist

(27) **EXAMINATION INFORMATION:**

Do you wish to self schedule your examination on line ☐ Yes ☐ No **(If No, please complete the exam questions below)**
(If Yes, the department will notify you by email with instructions once your application has been processed)

Desired Location___ (LA) Los Angeles, (SD) San Diego, (SF) San Francisco, (SA) Sacramento, (CL) Clovis (usually the second and fourth Saturday).

a.m. ___

Desired Date _____ p.m. ___ If we are unable to provide you with the date selected, you will be scheduled the next available date.

List any dates that you are not available: _____

*Mandatory pursuant to Cal. Ins. Code, § 1666.5; Cal. Civil Code, § 1798.17; Cal. Family Code, § 17520(d); and Federal Privacy Act of 1974, §§7(a)(2)(B) and 7(b).
**Form LIC-050 (05/2003) must be completed and submitted with Surplus and/or the Special Lines' Surplus Broker Application

(28) **WORK/PERSONAL HISTORY**

Account for all time for the past five years. Give all employment experiences starting with your current employer working back five years. Include full and part-time work, self-employment, military service, unemployment, and full-time education. Attach separate sheet, if needed.

	From Month	From Year	To Month	To Year	Position Held
Name					
City State					
Name					
City State					
Name					
City State					
Name					
City State					

(29) **DO YOU NOW HOLD, OR HAVE YOU EVER HELD, AN INSURANCE LICENSE AS A RESIDENT IN THIS STATE OR ANY OTHER STATE?** ..... ☐ Yes ☐ No

Type of License	State or Province	Date License Held	Is License in Force

30 AKA/ALIAS

Are you now using or have you ever used any name other than shown?..... ☐ Yes ☐ No

If yes, list names, dates and reason(s) used:

Last	First	Middle	Suffix	Dates Used	Reason Used

31 FICTITIOUS NAMES:

Do you intend to use a fictitious (DBA) name? ☐ Yes ☐ No

.....

If yes, list the name: (This name must be approved by the Department prior to use.) _____

_____

32 LIFE AGENT/PART TIME FRATERNAL LICENSE APPLICANTS ONLY:

Are you intending to act as a Variable Contract Agent?..... ☐ Yes ☐ No

Are you registered with SECO or NASD? ..... ☐ Yes ☐ No

CRD#_____If CRD# is not provided, acceptable proof of registration must be attached before the authority may be granted. If acceptable proof is not submitted, license may be issued without Variable Contract authority.

33 LIFE AGENT LICENSE APPLICANTS ONLY:

Do you intend to limit your activity to the sale of funeral and burial expense policies in accordance with Section 1749.01 of the California Insurance Code? ☐ Yes ☐ No

.....

34 PRELICENSING CERTIFICATES:

Do you certify that you have completed your prelicensing education? If no, your prelicensing education must be completed prior to taking your examination.

If yes, you must provide the completion date: ☐ Yes ☐ No

Background Information

35 The Applicant must read the following very carefully and answer every question:

Federal law (18 U.S.C. 1033) prohibits anyone who has been convicted of a felony involving dishonesty or a breach of trust or who has been convicted of **any** violation of 18 U.S.C. 1033 and 1034 from conducting the business of insurance unless they have obtained the written consent of the Insurance Commissioner. It is a violation of this statute to conduct the business of insurance without the Commissioner's written consent. If you have been convicted of a felony involving dishonesty or a breach of trust or a violation of 18 U.S.C. 1033 and 1034, then you must obtain written consent. **If you have not obtained this written consent you must do so prior to filing your application. DO NOT SUBMIT THIS APPLICATION UNTIL YOU HAVE DONE SO.** If you have received consent, a copy of your consent letter must be attached to this application. If you are applying for a non-resident license, attached a copy of the written consent letter issued by your home state. Instructions to apply for the written consent are available on the CDI's Web site at www.insurance.ca.gov.

1. Have you ever been convicted (please read definition of crime below before answering) of, or are you currently charged with, committing a crime, whether or not adjudication was withheld?..... ☐ Yes ☐ No

"Crime" includes a felony, a misdemeanor or military offense. "Convicted" includes, but is not limited to, having been found guilty by a verdict of a judge or jury, having entered a plea of nolo contendere, no contest, having had any charge expunged, dismissed or plea withdrawn pursuant to Penal Code Section 1203.4, or having been given probation, a suspended sentence or a fine. You may exclude traffic citations and juvenile offenses tried in juvenile court. You should answer "yes" if you have been convicted of a felony or a misdemeanor including driving offenses such as, but not limited to reckless driving, driving under the influence and driving with a suspended license, whether or not you spent any time in jail, and whether or not you believe the conviction has been removed from your record.
If you answer yes, you must attach to this application:

a) a written statement with original signature explaining the circumstances of each incident,
b) a certified copy of the charging document, and
c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgement.

2. Have you or any business in which you are or were an owner, partner, officer or director ever been involved in an administrative proceeding regarding any professional or occupational license? ☐ Yes ☐ No

"Involved" means having a license censured, suspended, revoked, canceled, terminated; or being assessed a fine, placed on probation or surrendering a license to resolve an administrative action. "Involved" also means being named a party to an administrative or arbitration proceeding which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid denial. You may exclude terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

a) a written statement, with original signature, identifying the type of license and explaining the circumstances of each incident,
b) a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has any demand been made or judgment rendered against you for any overdue monies by any insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding? ☐ Yes ☐ No

If you answer yes, submit a statement, with an original signature, summarizing the details of the indebtedness and arrangements for repayment, and/or type and location of bankruptcy.

4. Have you ever been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment greement?..... ☐ Yes ☐ No

If you answer yes, identify the jurisdiction(s): _____

5. Are you currently a party to, or have you ever been found liable in, any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty?..... ☐ Yes ☐ No

If you answer yes, you must attach to this application:

a) a written statement, with original signature, summarizing the details of each incident,
b) a copy of the Petition, Complaint, or other document that commenced the lawsuit or arbitration, and
c) a copy of the official document which demonstrates the resolution of the charges or any final judgment.

6. Have you or any business in which you are or were an owner, partner, officer or director ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct?..... ☐ Yes ☐ No

If you answer yes, you must attach to this application:

a) a written statement, with original signature, summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
b) copies of any relevant documents.

(30) APPLICANT'S CERTIFICATION:

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE READ THE FOREGOING APPLICATION AND KNOW THE CONTENTS THEREOF AND THAT EACH STATEMENT THEREIN MADE IS FULL, TRUE AND CORRECT. I UNDERSTAND THAT PURSUANT TO SECTIONS 1668(h) AND 1738 OF THE INSURANCE CODE, ANY FALSE STATEMENT MAY SUBJECT MY APPLICATION TO DENIAL AND MAY SUBJECT MY LICENSE(S) TO SUSPENSION OR REVOCATION. FURTHER, PURSUANT TO INSURANCE CODE SECTIONS 1703 AND 1733, I AUTHORIZE DISCLOSURE TO THE INSURANCE COMMISSIONER OF ALL FINANCIAL INSTITUTION RECORDS OF ANY FIDUCIARY ACCOUNTS FOR THE DURATION OF THIS LICENSE.

ALL FEES ARE FILING FEES AND ARE NOT REFUNDABLE OR TRANSFERABLE, WHETHER OR NOT THE APPLICATION IS ACTED UPON OR THE EXAMINATION TAKEN.

APPLICANT'S SIGNATURE: _____ CITY _____ DATE _____

NOTICE: INFORMATION COLLECTION AND ACCESS

Section 1798.17 of the California Civil Code requires the following information to be provided when collecting information from individuals to determine compliance with the group and corporate practice provisions of the law, and to establish positive identification, to match the names of the certified list provided by the Department of Child Support Services to applicants and licensees, and of responding to requests for this information made by child support agencies.

AGENCY: Department of Insurance **ADDRESS:** 320 Capitol Mall, Sacramento, CA 95814–4309 **TELEPHONE NUMBER:** (800) 967–9331 or (916) 322–3555

TITLE OF OFFICIAL RESPONSIBLE FOR INFORMATION MAINTENANCE: Chief, Producer Licensing Bureau

AUTHORITY WHICH AUTHORIZES THE MAINTENANCE OF THE INFORMATION: California Insurance Code, Chapters 5, 6, 7, 8–Part 2, Division 1

THE CONSEQUENCES, IF ANY, OF NOT PROVIDING ALL OR PART OF THE REQUESTED INFORMATION: It is mandatory that you provide all information requested. Omission of any item of requested information will result in the application being rejected as incomplete.

THE PRINCIPAL PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED: The information requested will be used to determine qualifications for licensure or certification, to determine compliance with the group and corporate practice provisions of the law and to establish positive identification.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW OWN PERSONAL FILES MAINTAINED BY THE AGENCY SUBJECT TO ANY LIMITATIONS UNDER THE INFORMATION PRACTICES ACT OF 1977, CIVIL CODE SECTION 1798.40, AND EXEMPTIONS UNDER THE CALIFORNIA PUBLIC RECORDS ACT, GOVERNMENT CODE SECTION 6254.

INSTRUCTIONS FOR COMPLETING APPLICATION

RE: "LICENSE TYPE" a separate application is required for each license type requested

RE: "APPLICANT NAME" Enter full legal name. If no middle name, enter (NMN). If any part of your legal name is an initial only, place parentheses around such initial.

RE: "ADDRESS INFORMATION" Do not enter the word "same" in any address area. Enter the appropriate address. P. O. BOX is **not** acceptable for a resident or business address. Business and mailing addresses are public record and are available to the public. **It is the applicants/licensees responsibility to notify the department of any change in address.**

RE: "ARE YOU A CITIZEN OF THE UNITED STATES" If no is answered, the applicant must supply a copy of both sides of the work authorization.

RE: "EXAM INFORMATION" Examinations are administered daily, Monday through Friday at 8:30 a.m. and 1:00 p.m., in Los Angeles (LA), San Diego (SD), San Francisco (SF) and Sacramento (SA). An examination is also administered twice monthly in Clovis usually the second and fourth Saturday of the month at 8:30 a.m. If you fail to appear for a scheduled examination, an additional examination fee will be required for rescheduling.

RE: "PREVIOUS LICENSE HISTORY INFORMATION" If currently licensed as a resident in another state, upon becoming a California resident, a clearance letter from the previous state of residence is also required.

RE: "AKA/ALIAS" List previously and currently used aliases and maiden names, if any. If you are currently using an "also known as" (AKA) name which you desire to be noted on record, so state. Abbreviations of true name or "nick" names are not acceptable.

RE: "BACKGROUND QUESTIONS" If you answer yes to any of these questions, you must submit a signed statement, with your original signature summarizing the details of each event. You must also provide the additional certified documentation described with each question.

PRELICENSING EDUCATION REQUIREMENTS: Effective 1/1/92 all new applicants must:

A) take an approved minimum 40–hour class for the fire and casualty broker–agent license exam, and/or;
B) take an approved minimum 40–hour class for the life agent license exam, and/or;
C) take an approved minimum 20–hour class for the personal lines broker–agent license exam,
D) and take an approved minimum 12–hour class on ethics and the California Insurance Code.

An applicant will be taking either 52 hours (40 and 12) or 92 hours (40 and 40 and 12) of prelicensing class hours depending on whether one or both licenses are being sought. The Personal Lines Broker–Agent applicant is required to complete 32 hours (20 and 12) of prelicensing classroom hours. Original certificates must be signed and submitted with the application.

ADDITIONAL FILING REQUIREMENTS:

The following documents are required to be submitted with the application for the specific license types as listed:

MC – Action Notice of Appointment (Form 447–54A (Rev. 03/2006)) from the sponsoring insurance company.
SL – $50,000 bond (Form 447–31 (Rev. 1/2003)) with a properly executed Power of Attorney form attached.
SP – $10,000 bond (Form 447–32 (Rev. 1/2003)) with a properly executed Power of Attorney form attached.
CS – $10,000 bond (Form 447–70 (Rev. 12/2003)) with a properly executed Power of Attorney form attached.
CI – Action Notice of Appointment (Form 447–54A (Rev. 03/2006)) from the sponsoring insurance company and/or Business Entity Endorsement (Form 411–8A (Rev. 12/2003)) completed by sponsoring Business Entity.

The following documents may be submitted with the initial application. Submitting these documents at a later date will not delay the issuance of your license, however, no authority to transact insurance will be granted until such time as the document has been received. If submitting an online application, these documents are to be submitted after your license is issued:

PF – Action Notice of Appointment (Form 447–54A (Rev. 03/2006)) from the sponsoring fraternal benefit society or association admitted to California.
LX – Action Notice of Appointment (Form 447–54A (Rev. 03/2006)) from the sponsoring insurance company and/or; Business Entity Endorsement (Form 411–8A completed by sponsoring business entity. To be granted variable authority acceptable proof of registration with SECO or NASD must be submitted with application and you must be appointed by an insurer authorized for variable contracts. Failure to submit proof of registration will result in license being issued without variable authority.
TA –Action Notice of Appointment (Form 447–54A (Rev. 03/2006)) from the sponsoring insurance company.
FX/PL – License authority is determined by what documents are submitted. To act as a:
BROKER – $10,000 bond (Form 417–5 (Rev. 10/2002)) with properly executed Power of Attorney form attached and/or Business Entity Endorsement (Form 411–8A (Rev. 12/2003)) completed by sponsoring Business Entity.
AGENT – Action Notice of Appointment (Form 447–54A (Rev. 03/2006)) from the sponsoring insurance company and/or Business Entity Endorsement (Form 411–8A (Rev. 12/2003)) completed by sponsoring Business Entity.
SOLICITOR – Action Notice of Solicitor (Form 417–31 (Rev. 7/95)) completed by the sponsoring insurance agent or broker.

> To obtain insurance licensing FORMS by mail, send request to: Department of Insurance, 320 Capitol Mall, Sacramento, CA 95814, or you may phone Sacramento toll free at (800) 967–9331 or (916) 322–3555, press 3. Forms are also available on our Web site at **http://www.insurance.ca.gov**

> To obtain insurance licensing information, you may phone our Sacramento office toll free at (800) 967–9331 or (916) 322–3555. You may also obtain licensing information and a complete list of licensing fees by visiting our Web site at http://www.insurance.ca.gov

>

> MAIL APPLICATION WITH ATTACHMENTS AND FEES TO: DEPARTMENT OF INSURANCE
P. O. BOX 1139
SACRAMENTO, CA 95812–1139

(b) Form 441–11 for organizations.

For Department Use Only
License #_____
Effective Date_____
WS#_____

State of California – Department of Insurance
Business Entity Application
for Insurance License
(Type or print clearly)

①BUSINESS ENTITY TYPES: (check only one please)	☐ Limited Liability Company
	☐ Nonprofit Corporation
☐ Corporation	☐ Unincorporated Association
☐ General Partnership	☐ Limited Liability Partnership/Limited Partnership

②LICENSE TYPE:	☐ Self-Service Storage Agent (SS)
☐ Life Agent (LX)	☐ Communication Equipment Insurance Agent (CV)
☐ Fire & Casualty Broker-Agent (FX)	☐ Surplus Line Broker (SL)
☐ Personal Lines Broker-Agent (PL)	☐ Special Lines' Surplus Line Broker (SP)
☐ Credit Insurance (CI)	☐ Life & Disability Analyst (LA)
☐ Rental Car Agent (RC)	☐ Cargo Shipper's Agent (CS)
☐ Motor Club (MC)	☐ Vehicle Service Contract Provider (VS)

③Business Entity Name		
④Federal Employer Identification Number – – – – – – – – –	⑤Incorporation /Formation date month day year	⑥ State of Incorporation: Attach copy of Certificate of Good Standing
⑦Business Address (P.O. Box not acceptable.)	⑧ City	⑨ State ⑩Zip Code
⑪Business Phone Number ( ) -	⑫Business Fax Number ( ) -	⑬ Business E-mail Address / ⑭ Business Web Site Address
⑮Mailing Address (P. O. Box is acceptable)	⑯ City	⑰ State ⑱Zip Code

⑲ FICTITIOUS NAMES:

A. Does the business entity intend to use a fictitious (DBA) name? ☐ Yes ☐ No

If yes, list such name: (This name must be approved by the Department prior to use.) _____

B. Is the business entity now or has it ever used any name other than shown? ☐ Yes ☐ No

If yes, list names, dates and reason(s) used.

_____

⑳ BUSINESS ENTITY INFORMATION:

Is this business entity engaged in any business or activity other than insurance? ☐ Yes ☐ No

If yes, answer the following:

A. What is the nature of this other business or activity?_____

B. What percentage of the business entity 's net income will be derived from this other business or activity?_____

IMPORTANT: Business entity applicants engaged in business other than insurance are cautioned to review the laws governing such other business to ensure that the transacting of insurance is not incompatible under such laws.

㉑ Is the business entity an insurer? ☐ Yes ☐ No

㉒ DOES THE BUSINESS ENTITY HOLD OR HAS IT EVER HELD AN INSURANCE LICENSE AS A RESIDENT IN ANY STATE, INCLUDING THE STATE OF CALIFORNIA? ☐ Yes ☐ No

If yes, complete the following: (attach a separate sheet if needed)

Type of License and License Number	State or Province	Date License Held	Is License In Force?

㉓ FIRE & CASUALTY BROKER-AGENT APPLICANTS ONLY:

Do you intend to act in the capacity of a Vehicle Service Contract Administrator? ☐ Yes ☐ No

Do you intend to act in the capacity of a Vehicle Service Contract Refund Agreement Administrator? ☐ Yes ☐ No

㉔ VEHICLE SERVICE CONTRACT PROVIDER APPLICANTS ONLY:

Do you intend to act in the capacity of a Vehicle Service Contract Refund Agreement Obligor? ☐ Yes ☐ No

㉕ LIFE AGENT LICENSE APPLICANTS ONLY:

Does the business entity intend to act as a Variable Contract Agent? ☐ Yes ☐ No

Any business entity intending to act as a Variable Contract Agent must have at least one Designated/Responsible Licensed Producer authorized as a Variable Contract Agent.

DESIGNATED/RESPONSIBLE LICENSED PRODUCER

㉖ Identify all Designated/Responsible Licensed Producers*

Name_____ SSN**_____ License #_____

Name_____ SSN**_____ License #_____

Name_____ SSN**_____ License #_____

Name_____ SSN**_____ License #_____

(Attach a separate sheet if needed)

*The designees listed above are not required to complete Form 411–8A (Rev. 12/2003)

BUSINESS ENTITY DISCLOSURE

(27) **Identify all partners, members, officers, directors, managers, controlling persons and any shareholders owning 10% or more interest in the business entity***

*If partnership, attach copy of partnership agreement, if any. If no agreement, so state.

Name_____ Title_____ SSN/FEIN**_____ % of ownership_____

Name_____ Title_____ SSN/FEIN**_____ % of ownership_____

Name_____ Title_____ SSN/FEIN**_____ % of ownership_____

Name_____ Title_____ SSN/FEIN**_____ % of ownership_____

Name_____ Title_____ SSN/FEIN**_____ % of ownership_____

Name_____ Title_____ SSN/FEIN**_____ % of ownership_____

(28) CONTROLLING PERSON:

A "Controlling Person" includes: individual, corporation, partnership, limited liability company, limited partnership or trust.

You the applicant, must identify the Controlling Person, including the president, chief executive officer, chairman of the board, those people that own 10% or more of the stock and any other person who directly or indirectly possess the power to control the affairs of the business entity.

Is there any business entity, such as a holding company, which acts in the capacity of a Controlling Person as defined in Section 1668.5 of the California Insurance Code?..... ☐ Yes ☐ No

If yes, you must identify the president, chief executive officer, chairman of the board, those people that own 10% or more of the stock and any person who directly or indirectly possess the power to control the affairs of the business entity. (Attach separate sheet if more space is needed)

Name_____ SSN**_____

Name_____ SSN**

(29) SURPLUS LINE AND/OR SPECIAL LINES' SURPLUS LINE APPLICANTS ONLY:

Notification of your filing for a Surplus Line Brokers' license will be forwarded to the Surplus Line Association of California, who will notify you as to their filing rules (California Code of Regulations, Title 10, Section 2172).

List names of all insurers not admitted to California with whom arrangements have been made to accept or who are considering the acceptance of surplus line business offered by the business entity: _____

_____

SURPLUS LINE OR SPECIAL LINES' BUSINESS ENTITY ENDORSEMENT AUTHORIZATION

List name of each person applying to transact under the authority of this license type, and their relationship to the business entity. (Relationship to the business entity must be that of an EMPLOYEE, OFFICER, PARTNER, MEMBER, OR MANAGER as appropriate to the organization application.) A separate application form 441-9 must be completed by each person named below, and attached to this business entity application.

Name_____ SSN**_____ License #_____

Name_____ SSN**_____ License #_____

Name_____ SSN**_____ License #_____

**** Mandatory pursuant to Cal. Ins. Code, §1666.5; Cal. Civil Code §1798.17; Cal. Family Code § 17520(d); and the Federal Privacy Act of 1974 §§7(a)(2)(B) and 7(b).**

BACKGROUND INFORMATION

Please read the following very carefully and answer every question:

(30) Has the business entity or any of its partners, members, controlling persons, officers, directors, managers, or any shareholders owning 10% or more interest in the business entity, ever been convicted of, or is the business entity or, any partner, member, controlling person officer director, manager or any shareholders owning 10% or more interest in the business entity currently charged with, committing a crime, whether or not adjudication was withheld?..... ☐ Yes ☐ No

"Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses. "Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having had any charge dismissed or plea withdrawn pursuant to Penal Code Section 1203.4, or having been given probation, a suspended sentence or a fine.

If you answer yes, you must attach to this application:

d) a written statement with original signature explaining the circumstances of each incident,
e) a certified copy of the charging document, and
f) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment

(31) Has the business entity or any of its partners, members, controlling persons, officers, directors, managers or any shareholders owning 10% or more interest in the business entity, ever been involved in an administrative proceeding regarding any professional or occupational license?..... ☐ Yes ☐ No

"Involved" means having a license censured, suspended, revoked, canceled, terminated; or, being assessed a fine, placed on probation or surrendering a license to resolve an administrative action. "Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license. "Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to noncompliance with continuing education requirements or failure to pay a renewal fee.

If you answer yes, you must attach to this application:

a) a written statement with original signature identifying the type of license and explaining the circumstances of each incident,
b) a certified copy of the Notice of Hearing or other document that states the charges and allegations, and
c) a certified copy of the official document which demonstrates the resolution of the charges or any final judgment.

(32) Has any demand been made or judgment rendered against the business entity or any of its partners, members, controlling persons, officers, directors, managers or any shareholders owning 10% or more interest in the business entity for overdue monies by an insurer, insured or producer, or have you ever been subject to a bankruptcy proceeding?..... ☐ Yes ☐ No

If you answer yes, submit a statement summarizing the details of the indebtedness and arrangements for repayment.

(33) Has the business entity or any of its partners, members, controlling persons, officers, directors, managers or any shareholders owning 10% or more interest in the business entity, ever been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement?..... ☐ Yes ☐ No

If you answer yes, identify the jurisdiction(s): _____

(34) Has the business entity or any of its partners, members, controlling persons, officers, directors, managers or any shareholders owning 10% or more interest in the business entity, a party to, or ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, misrepresentation or breach of fiduciary duty?..... ☐ Yes ☐ No

If you answer yes, you must attach to this application:

a) a written statement with original signature summarizing the details of each incident,
b) a copy of the Petition, Complaint or other document that commenced the lawsuit or arbitration, and
c) a copy of the official document which demonstrates the resolution of the charges or any final judgment.

(35) Has the business entity or any of its partners, members, controlling persons, officers, directors, managers or any shareholders owning 10% or more interest in the business entity, ever had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct?..... ☐ Yes ☐ No

If you answer yes, you must attach to this application:

a) a written statement with original signature summarizing the details of each incident and explaining why you feel this incident should not prevent you from receiving an insurance license, and
b) copies of all relevant documents.

➢ IMPORTANT NOTICE FOR LIMITED LIABILITY COMPANIES:

Section 1647.5(c) of the California Insurance Code (CIC) requires Limited Liability Company licensees (limited to Fire and Casualty, Life, Surplus Lines, Special Lines, or Cargo Shipper agents) to file with the Insurance Commissioner an annual confirmation demonstrating continuing compliance with the financial security requirements of Section 1647.5 CIC. This annual confirmation is typically satisfied by submitting proof of errors and omissions liability insurance coverage. The aggregate dollar amount of errors and omissions coverage can be in the form of cash, bonds, bank certificates of deposit, U.S. Treasury obligations, etc., held to provide security for claims against the Limited Liability Company. (The amount required over the minimum of $500,000 is at least $100,000 multiplied by the number of licensees rendering professional services on behalf of the company; however, the maximum amount is not required to exceed $5,000,000.00.)

For the purposes of satisfying this requirement, you are required to provide one of the following:

1. Complete and return the enclosed Certificate of Coverage (form LIC CC1) signed by a representative of the insurance company providing the errors and omissions policy (Form LLC CC1 is available from the departmental website at www.insurance.ca.gov); or,

2. If assets other than the errors and omissions liability insurance are being used to satisfy the security requirements, provide verification from the bank or escrow holder listing the type of asset and the current dollar amount.

APPLICANT'S CERTIFICATION:

I (we) certify (or declare) under penalty of perjury that:

(a) the named business entity intends actively and in good faith to carry on an insurance business with the general public;

(b) the business entity's articles of incorporation or articles of organization or association or partnership agreement, as the case may be, do not forbid it to act in the capacity for which this application is being made;

(c) the holding of the license hereby applied for is not incompatible with the laws, rules or regulations of any federal, state, county or municipal government for which it performs work (if any) by which it is licensed (if any);

(d) if the license is granted, only those natural persons so authorized will transact insurance under each license;

(e) (Surplus Line and Special Lines' applicants only) - we apply for a license pursuant to the provisions of Chapter 6, Part 2, Division 1 of the Insurance Code of the State of California permitting the solicitation, negotiation and subject to the provision of said Chapter, the effecting of insurance to be procured from or placed with insurers not authorized to transact insurance business in this State.

Further, I (we) certify (or declare) under penalty of perjury that I (we) have read the foregoing application and know the contents thereof and that each statement therein made is full, true and correct. I (we) understand that pursuant to Sections 1668 (h) and 1738 of the Insurance Code, any false statements may subject my application to denial and may subject my license(s) to suspension or revocation. Further, pursuant to Insurance Code Sections 1703 and 1733, I (we) authorize disclosure to the Insurance Commissioner of all financial institution records of any fiduciary accounts for the duration of this license.

(36)

➢ SIGNATURE(S) _____ Title _____

_____ Title _____

(type name and title)

_____ Title _____

_____ Title _____

(type name and title)

_____ Title _____

_____ Title _____

(type name and title)

_____ Title _____

_____ Title _____

(type name and title)

➢ DATE EXECUTED _____, AT _____, ____

(month, day, year) (city) (state)

BUSINESS PHONE # ( ) _____

IMPORTANT NOTICE

If organization is a partnership, each partner must sign this application.

If organization is a corporation, an officer having authority to bind the organization must sign.

If organization is a limited liability company, an officer, member or manager having authority to bind the organization must sign.

If organization is a nonprofit corporation or unincorporated association, all members must sign.

➢ **ALL FEES ARE FILING FEES AND ARE NOT REFUNDABLE OR TRANSFERABLE, WHETHER OR NOT THE APPLICATION IS ACTED UPON OR THE EXAMINATION TAKEN.**

Name of Business Entity_____

FEIN #_____

ACTION NOTICE OF APPOINTMENT*

Pursuant to Sections 1704 through 1707 and/or 1673 or 1756 of the Insurance Code

Filing fees required for each appointment submitted.

*If this appointment form is completed by the insurer, Form 447–54A (Rev. 03/2006) is not required

Appointment Types: FX: Fire and Casualty LX: Life DO: Disability Only PL: Personal Lines CI: Credit Insurance
RC: Rental Car Applicants must complete a Rental Car Agent Notice of Appointment, Form RCA 3

Insurer Name: _____

FEIN: _____ NAIC # _____ CA Company # _____ Appointment Type_____
Federal Employer Identification Number

Signature of insurer: Signature must be that of an officer of the Company or a person authorized under a Special Power of Attorney on file with the Department.

_____

Name Official Title Date

Phone Number (___)_____

Insurer Name: _____

FEIN: _____ NAIC # _____ CA Company # _____ Appointment Type_____
Federal Employer Identification Number

Signature of insurer: Signature must be that of an officer of the Company or a person authorized under a Special Power of Attorney on file with the Department.

_____

Name Insurer Official Title Date

Phone Number (___)_____

Insurer Name: _____

FEIN: _____ NAIC # _____ CA Company # _____ Appointment Type_____
Federal Employer Identification Number

Signature of insurer: Signature must be that of an officer of the Company or a person authorized under a Special Power of Attorney on file with the Department.

_____

Name Insurer Official Title Date

Phone Number (___)_____

Please note: Form 447–54A (Rev. 03/2006) and filing fee must be submitted for each additional appointment.

NOTICE: INFORMATION COLLECTION AND ACCESS

Section 1798.17 of the California Civil Code requires the following information to be provided when collecting information from individuals to determine compliance with the group and corporate practice provisions of the law, and to establish positive identification, to match the names of the certified list provided by the Department of Child Support Services to applicants and licensees, and of responding to requests for this information made by child support agencies.

AGENCY: Department of Insurance **ADDRESS:** 320 Capitol Mall, Sacramento, Ca 95814–4309 **TELEPHONE NUMBER:** (800) 967–9331 or (916) 322–3555

TITLE OF OFFICIAL RESPONSIBLE FOR INFORMATION MAINTENANCE: Chief, Producer Licensing Bureau

AUTHORITY WHICH AUTHORIZES THE MAINTENANCE OF THE INFORMATION: California Insurance Code, Chapters 5, 6, 7, 8–Part 2, Division 1

THE CONSEQUENCES, IF ANY, OF NOT PROVIDING ALL OR PART OF THE REQUESTED INFORMATION: It is mandatory that you provide all information requested. Omission of any item of requested information will result in the application being rejected as incomplete.

THE PRINCIPAL PURPOSES (S) FOR WHICH THE INFORMATION IS TO BE USED: The information requested will be used to determine qualifications for licensure or certification, to determine compliance with the group and corporate practice provisions of the law and to establish positive identification.

EACH INDIVIDUAL HAS THE RIGHT TO REVIEW OWN PERSONAL FILES MAINTAINED BY THE AGENCY SUBJECT TO ANY LIMITATIONS UNDER THE INFORMATION PRACTICES ACT OF 1977, CIVIL CODE SECTION 1798.40, AND EXEMPTIONS UNDER THE CALIFORNIA PUBLIC RECORDS ACT, GOVERNMENT CODE SECTION 6254.

- INSTRUCTIONS FOR COMPLETING BUSINESS ENTITY APPLICATION

RE: "BUSINESS ENTITY TYPE":

CORPORATION – if already incorporated, attach a copy of your Certificate of Good Standing. If corporation has been formed as a result of a merger, submit a copy of your approved merger papers.

PARTNERSHIP – attach a copy of the partnership agreement (if any). If no agreement, so state on application. **The PARTNERSHIP'S FEDERAL IDENTIFICATION NUMBER IS MANDATORY** and must be entered in the space shown.

LIMITED LIABILITY COMPANY – attach a copy of your approved articles of organization. Additional requirements are listed on page 4. This documentation must be submitted with your application.

RE: "BUSINESS ENTITY NAME":

The true business entity name must be entered. Include commas, hyphens, ampersands, etc. This name is subject to disapproval by the Insurance Commissioner.

RE: "FICTITIOUS NAME":

If you intend to transact insurance in a name other than the true business entity name, enter such fictitious name. This name is subject to disapproval by the Insurance Commissioner.

RE: "DESIGNATED/RESPONSIBLE LICENSED PRODUCER":

You must list all licensed producers intending to transact on behalf of the business entity. All unlicensed producers intending to transact on behalf of the business entity must complete form 441–9.

RE: "CONTROLLING PERSON":

Insurance Code Section 1668.5(b), in part, defines a "controlling person" as a person who possesses the power to direct or cause the direction of the management and policies of the business entity.

RE: "BACKGROUND INFORMATION":

If the answer is "yes" to any of these questions, you must submit required documentation.

RE: "APPLICANT'S CERTIFICATION":

Partnership – each partner of the partnership must sign. **Corporation or Association** – an officer having authority to bind the Corporation or Association must sign.

FEES

A) Licenses are issued for a two–year term, which begins the date the first license is issued to the business entity and ends the last day of that calendar month two years later. Subsequent licenses are issued for the balance of the established license term.

B) **Fees:** Filing fees are required for each business entity application submitted, except that Surplus Line or Special Lines' fees may vary – see below:

SURPLUS AND SPECIAL LINES' FILING FEES:

1) One filing fee covers the first **TWO** natural persons named under either of these license types. An additional filing fee is required for each subsequent natural person to be named on the license.

2) Fees collected from one person for either the Surplus Line or Special Lines' license cover that person's fees for both licenses.

C) Total fee due is determined by adding the appropriate filing fees in (A) and (B) above to other applicable fees listed in enclosed fee chart.

> **PLEASE REVIEW THE APPLICATION CAREFULLY AFTER COMPLETION. ANY OMISSIONS OR DEFICIENCIES WILL RESULT IN A DELAY IN THE PROCESSING OF YOUR APPLICATION FOR LICENSE.**

> **MAIL APPLICATION WITH FEES TO: DEPARTMENT OF INSURANCE**
P. O. BOX 1139
SACRAMENTO, CA 95812–1139

> **DIRECT QUESTIONS REGARDING THIS FILING TO THE PRODUCER LICENSING BUREAU IN SACRAMENTO, (800) 967–9331 or (916) 322–3555**

> **ALL FEES ARE FILING FEES AND ARE NOT REFUNDABLE OR TRANSFERABLE, WHETHER OR NOT THE APPLICATION IS ACTED UPON OR THE EXAMINATION TAKEN.**

(c) Form Lic. SSA 1.

The list of authorized endorsees shall be made on Form Lic. SSA 1. The list shall be maintained in a format capable of transmission to the Commissioner or a designee of the Commissioner electronically and in hard copy or diskette, however requested by the Commissioner or a designee of the Commissioner pursuant to Section 2194.15(c) above. The electronic version shall be transmitted in commercial word–processing or spreadsheet form. When requested, the list shall be updated to include endorsees newly authorized up to thirty (30) days before the mailing date of the request, and shall include the dates upon which each endorsee's authorization began and, if relevant, terminated. It shall then be transmitted

as an attachment to the e–mail or by regular mail in hard copy or diskette, as requested.

The appropriate e–mail or regular mailing addresses shall be posted by the Department on its website at http://www.insurance.ca.gov.

Authorized Endorsees — Self–Service Storage Facility
Form Lic. SSA 1

Producer Licensing Bureau
P.O. Box 1139
Sacramento, CA 95812–1139
Information: (800) 967–9331 Or (916) 322–3555
www.insurance.ca.gov

California Department of Insurance
Self–Service Storage Agent
Authorized Endorsees
Pursuant to CIC Section 1758.72(d)
Effective Date:_____

The listed endorsees, having met the training requirements of California Insurance Code Section 1758.72(a) are authorized to offer the following types of insurance in connection with the rental of self–service storage space.

1. Hazard insurance providing coverage to renters for the loss of, or damage to, tangible personal property in storage or in transit during the rental period, only in connection with and incidental to, self–service storage rental agreements.

Note: This form must be completed annually and maintained for a three year period pursuant to CIC section 1758.72(d)

Producer Licensing Bureau
P.O. Box 1139
Sacramento, CA 95812–1139
Information: (800) 967–9331 Or (916) 322–3555
www.insurance.ca.gov

California Department of Insurance
Self–Service Storage Agent
Authorized Endorsees
Pursuant to CIC Section 1758.72(d)

Location	Manager	Name of Employee(s)	Employee ID

(d) Form Lic. SSA 2.
The insurer certification shall be made on Form Lic. SSA 2.

Notice of Appointment — Self-Service Storage Facility
Form Lic. SSA 2

Producer Licensing Bureau
P.O. Box 1139
Sacramento, CA 95812–1139
Information: (800) 967–9331 Or (916) 322–3555
www.insurance.ca.gov

SELF–SERVICE STORAGE AGENT NOTICE OF APPOINTMENT
To California Insurance Commissioner
Pursuant to CIC Section 1758.71(a)(2)

Insurer Name: _____

FEIN: _____ NAIC # _____ CA Company #_____
Federal Employer Identification Number

To the Insurance Commissioner of the State of California: Notice is hereby given that effective from the date shown on this notice, the designated insurer hereby appoints the self–service storage facility named herein to act as its agent and certifies that it has satisfied itself that the named self–service storage facility is trustworthy and competent to act as its self–service storage agent.

Name of Self–Service Storage Facility _____
Social Security # / FEIN # _____
(*Mandatory pursuant to Cal. Ins. Code § 1666.5; Cal. Civil Code § 1798.17; Cal. Family Code § 17520(d); and Federal Privacy Act of 1974 §§7(a)(2)(B) and 7(b).)

Effective Date _____

CIC Section 1758.71 (a)(2) requires that an applicant for a self–service storage agent license under this article shall file with the commissioner a certificate by the insurer that is to be named in the self–service storage agent license, stating that the insurer has satisfied itself that the named applicant is trustworthy and competent to act as its insurance agent limited to this purpose and that the insurer will appoint the applicant to act as its agent to transact the kind or kinds of insurance that are permitted by this article, if the self–service storage agent license applied for is issued by the commissioner.

Section 1798.17 of the California Civil Code requires the following information to be provided when collecting information from individuals to determine compliance with the group and corporate practice provisions of the law, and to establish positive identification, to match the names of the certified list provided by the Department of Child Support Services to applicants and licensees, and of responding to requests for this information made by child support agencies.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. This is executed on the ____ day of _____, _____.

Signature of insurer or managing agent of insurer: Signature must be that of an officer of the Company, managing agent, or a person authorized under a Special Power of Attorney on file with the Department.

_____
Name (print) Official Title (print) Date

Phone Number (____)_____

_____
Name of Insurer or managing agent
(print)

By: _____
(signature)

(e) Form Lic. SSA 3.

Training materials submitted to the Commissioner shall contain all of the elements set forth in Form Lic. SSA 3.

Register 2006, No. 42; 10–20–2006

Required Training Elements — Self-Service Storage Facility
Form Lic. SSA 3

Producer Licensing Bureau
P.O. Box 1139
Sacramento, CA 95812-1139
Information: (800) 967-9331 Or (916) 322-3555
www.insurance.ca.gov

California Department of Insurance
Self-Service Storage Agent
Outline of Required Training Elements

California Insurance Code Section 1758.72(a) requires all self-service storage agents to provide an insurance training program for its employees that shall meet specified minimum requirements. In an effort to assist you with developing your training program, we have provided you with the following checklist of required training elements to be covered in your materials.

1. Section 1758. 72(a)(1) requires that each employee receive instruction about the types of insurance specified in Section 1758.75, as follows, that are offered for sale to prospective renters.

- Insurance that provides hazard insurance coverage to renters for the loss of, or damage to, tangible personal property in storage or in transit during the rental period, and only in connection with, and incidental to, self-service storage rental agreements.

2. Section 1758.72(a)(2) requires that each employee receive training about ethical sales practices. Pursuant to 1758.78 a self-service storage agent shall not do any of the following:

- Offer to sell insurance except in conjunction with, and incidental to, authorized rental agreements.
- Advertise, represent, or otherwise portray itself or its employees as licensed insurers, insurance agents, or insurance brokers.

Section 1758.76(a) states that a licensee shall not sell insurance pursuant to this article unless all of the following conditions are satisfied: The self-service agent provides brochures or other written material to the prospective renter that does all of the following:

- Summarizes the material terms and conditions of coverage offered to renters, including the identity of the insurer.
- Describes the process for filing a claim, including a toll-free telephone number to report a claim.
- Discloses any additional information on the price, benefits, exclusions, conditions, or other limitations of the types of insurance specified in 1758.75 that the commissioner may by rule prescribe in regulation.
- Provide the licensee's name, address, telephone number, and license number and the availability of the department's toll-free consumer hotline.

3. Section 1758.72(a)(3) requires that each employee receive training about the disclosures to be given to prospective renter pursuant to subdivision (b) of Section 1758.76. The self-service storage agent makes all of the following disclosures to the renter, which shall be acknowledged in writing by the renter, or displayed by clear and conspicuous signs that are posted at every location where rental agreements are executed, such as the counter where a renter would sign a rental agreement:

- That the purchase by the renter of the insurance is not required in order to rent storage space. However, the licensee's employees may advise the renter that the self-service storage facility's rental agreement may contain provisions requiring the renter to provide insurance on his or her property in the storage unit.
- That the insurance policies offered by the self-service storage agent may provide a duplication of coverage already provided by a renter's homeowners insurance policy or by another source of coverage.
- That the self-service storage facility and its employees are not qualified or authorized to evaluate the adequacy of the purchaser's existing coverage.
- That if a renter elects to purchase the coverage, evidence of coverage must be stated on the face of the rental agreement or must be provided to the renter.
- That the insurance is provided under an individual, a group, or a master policy issued to the self-service storage agent by an insurer authorized to write the types of insurance specified in Section 1758.75 in this state.

(f) All forms set forth in their entirety in this section are available upon request, by telephone or in writing to the Department of Insurance or on the website of the Department of Insurance at www.insurance.ca.gov.

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Sections 1758.7, 1758.71 and 1758.72, Insurance Code.

HISTORY

1. *New section filed 6-30-2006 as an emergency; operative* 6-30-2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10-30-2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6-30-2006 order, including amendments to forms, transmitted to OAL 8-31-2006 and filed 10-16-2006 (Register 2006, No. 42).

§ 2194.17. Procedures.

(a) The following criteria shall apply to procedures employed by the Commissioner in considering and issuing licenses:

(1) If the application is deficient, the Commissioner shall, within twenty-one (21) calendar days of receipt of the license application, inform the applicant, in writing, that the application is deficient and what

specific information is required for completion. Absent notice of a deficiency, the application is deemed complete at the date of filing.

(2) The Commissioner shall, within thirty (30) calendar days of filing of a completed application, reach a decision whether to issue or deny a license, and shall notify the applicant of the decision. If the Commissioner has decided to deny the application, the reason(s) therefor shall be set forth in the notification.

(b) The periods set forth above shall be tolled in the event the application requires legal action by the Commissioner.

(c) The California Department of Insurance's median, minimum and maximum times for processing a license from the receipt of the initial completed application to the final license decision, and excluding applications that required legal action by the Commissioner, are as follows:

(1) thirty (30) calendar days (median time),

(2) fourteen (14) calendar days (minimum time),

(3) one (1) calendar year (maximum time)

NOTE: Authority cited: Sections 1758.7 and 1758.792, Insurance Code. Reference: Section 1670, Insurance Code.

HISTORY

1. New section filed 6–30–2006 as an emergency; operative 6–30–2006 (Register 2006, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–30–2006 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6–30–2006 order transmitted to OAL 8–31–2006 and filed 10–16–2006 (Register 2006, No. 42).

Subchapter 1.5. Advisory Organizations, Policy and Bond Form Approval

Article 1. Submission and Approval Procedures; Fees

§ 2195.1. Authority and Scope.

This subchapter is promulgated pursuant to Insurance Code sections 1855.1 through 1855.5. This subchapter shall only apply to advisory organizations and shall not be construed to require or permit advisory organizations to submit any documents to the Department of Insurance not provided for in the Insurance Code, or other subchapters of the California Code of Regulations. This subchapter shall be in addition to, and shall not apply to, any action or proceedings under Insurance Code sections 1858 through 1858.7.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.1 through 1855.5, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2195.2. Definitions.

(a) "Advisory organization" means every person other than an individual admitted insurer who:

(1) develops or prepares policy or bond forms, carries on research relative to the development and preparation of policy and bond forms for use in California by insurers, or who collects, compiles, or disseminates to insurers historical data on paid claims or reserves for reported claims, or related statistical information or data for actuarial analysis and acts in an advisory, as distinguished from a ratemaking, capacity and

(2) has filed with the Commissioner

(A) a copy of its constitution, articles of incorporation, agreement of association, and of its by–laws, or rules and regulations governing its activities,

(B) a list of its members and subscribers, and

(C) the name and address of a resident of this State upon whom notices or orders of the Commissioner or process may be served.

(b) "Applicant" means any advisory organization as defined in this subchapter applying for approval of a policy or bond form pursuant to California Insurance Code section 1855.5.

(c) "Application" means the transmittal letter and policy or bond form and other documentation which every advisory organization seeking approval of a policy or bond form pursuant to California Insurance Code section 1855.5(a) must file with the Form Filing Office. All applications must comply with sections 2195.2, 2195.3, 2195.4 and 2195.5 of this subchapter.

(d) "Form Filing Office" means that office within the office of the Insurance Commissioner in San Francisco designated for receipt of all applications filed pursuant to this subchapter. Facsimile transmissions and plastic bound documents shall not be filed with the Form Filing Office.

(e) "Policy or bond form" means any insurance policy, contract, rider, endorsement, insert policy page, or surety or guaranty bond developed or prepared by an advisory organization first printed on or after January 1, 1990, and made available for use by insurers on risks or operations in California as defined in Insurance Code section 1855.1.

(f) "First printed on or after January 1, 1990" means any form that was not printed and made available for use by insurers on risks or operations in California as defined in Insurance Code section 1855.1 by an advisory or rating organization prior to January 1, 1990.

(g) "Transmittal Letter" means the correspondence accompanying the policy or bond form filed for approval. Every transmittal letter shall comply with the requirements of section 2195.4(b).

(h) "Submission" means acceptance for review of a filed application by the Form Filing Office. The date of submission shall be the date an application is accepted for review pursuant to section 2196.1(b).

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.1, 1855.2, 1855.3, 1855.5 and 1855.5(a), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2195.3. Fees.

(a) A one hundred dollar ($100.00) fee shall be paid at the time an application is filed for submission.

(b) Applications which are not accompanied by the appropriate fee shall be rejected.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.5 and 12973.9, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order including amendment to subsections (a) and (b) transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2195.4. Filing Requirements.

All policy or bond forms developed or prepared by an advisory organization first printed on or after January 1, 1990, shall be filed with the Form Filing Office, in compliance with the following standards:

(a) All policy or bond forms shall be filed together with a transmittal letter.

(b) Every transmittal letter shall include the following information:

(1) Name and address of advisory organization

(2) Name, address and telephone number of contact person

(3) Title of form submitted
(4) Form number
(5) A general description of the form submitted
(6) Whether the form revises another form previously published by the advisory organization, and if so identifying the form or forms
(7) Whether the form revises another form previously filed with or approved by the Commissioner, and if so identifying the form or forms
(8) The fee indicated by section 2195.3(a).

(c) All filings shall include the fee set forth in section 2195.3.
(d) All filings shall include an original and three (3) copies of the application. Any person desiring an acknowledgement of the filing of an application must so request in their transmittal letter and must furnish an extra copy of the application together with a self–addressed envelope with postage fully prepaid.
(e) Applications filed pursuant to this subchapter shall be typewritten or printed on paper 8–1/2 inches wide and 11 inches long except that

[The next page is 528.3.]

forms or exhibits annexed thereto of a larger size shall be folded to the 8–1/2 inches wide and 11 inches long size. Unless pre–printed, the impression shall be on one side of the paper only. Pages of documents shall be consecutively numbered and fastened together in any suitable manner except plastic binding. Reproduction may be by any process, except facsimile machine, provided that all copies are clear and legible.

(f) All proposed policy(ies), form(s) or endorsement(s) must be submitted in an easily readable condition. Printer's proofs, typewritten or photostatic copies, or other legible copies, other than by facsimile transmission, will be accepted. Plastic bound documents will not be accepted.

(g) Any employee of an advisory organization may submit an application on behalf of a advisory organization, provided that the transmittal letter is on the advisory organization's letterhead and is signed in ink and indicates the name and title of the employee.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.2, 1855.5, 1855.5(a) and 12973.9, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2195.5. Information Requirements.

(a) Each application shall include the following, if applicable:

(1) if the application relates to a new program or line of business, the applicant shall provide a written explanation of the purpose and intent of the new product;

(2) if the application is a revision or replacement of a previously approved form or a form previously made available to insurers for use in California, the application must describe each revision or replacement and the reasons for each revision or replacement, and must include copies of the revised or replaced form;

(3) if the application is a revision of a previously approved form or a form previously made available to insurers for use in California, the application must show a comparison of the new words with the words being replaced or, in lieu of this, bracket [] the words or matter to be omitted and underline the words or matter to be added on a separate copy of the form. The filing of a revised form or forms must fully describe the intended effect(s) of each element of the revision;

(4) if the application is for a form (such as a rider) which is designed to be used with another document (such as a policy), reference to the document or the type of document with which it is intended to be used shall be made, or, in lieu of this, a copy of the document or a sample of the type of document with which it is intended to be used may be included; a copy of the document or a sample of the type of document shall be provided upon request by the Department;

(5) if the application is submitted to respond or comply with a particular statute, case or decision, reference shall be made thereto including either a citation or a copy of the statute, case or decision.

(b) Any information required by section 2195.5(a) may be included in the transmittal letter or in a separate memorandum. If provided in a separate memorandum, the memorandum shall be attached to the transmittal letter.

(c) Applicants shall be required to provide such additional information as the Commissioner may require for purposes of review.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.2 and 1855.5(a), Insurance Code.

HISTORY

1. New section filed *10–5–90* as an emergency; operative *10–5–90* (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2195.6. Service and Computation of Time.

Whenever a writing is due from the Commissioner, an applicant or any other person, it may be served by mail or in person in accordance with the procedures set forth in section 2197.2(f) and the time for service shall be computed in accordance with section 2197.2(1).

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

Article 2. Actions on Approval

§ 2196.1. Review of Application.

(a) The Insurance Department may review any submitted application to determine whether or not the policy or bond form contents or the use thereof would be inconsistent with the Insurance Code or would result in activities and practices by insurers that are unfair, unreasonable or otherwise inconsistent with the Insurance Code.

(b) Within fifteen days of receipt by the Department, applications which are not in compliance with applicable procedural requirements of this subchapter or which the Commissioner chooses not to review, may be rejected. A rejection shall constitute an act by the Commissioner on the policy or bond form application and no application that has been rejected shall be deemed approved. In the case of a rejection, the Commissioner shall notify the applicant in writing of the reason(s) for the rejection. Acceptance of a application is not a determination that the application complies with all requirements and shall not constitute a waiver of any requirements.

(c) The Commissioner may allow or require an applicant to modify, supplement, or amend an application.

(d) A rejection shall be effective on the date it is served.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(a) and (b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4– 90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).
4. Editorial correction of printing error in subsection (b) (Register 91, No. 46).

§ 2196.2. Approval of Applications.

(a) Reviewed applications shall be approved if the Commissioner determines that the policy or bond form contents or the use thereof would be consistent with the Insurance Code and would not result in activities and practices by insurers that are unfair, unreasonable or otherwise inconsistent with the Insurance Code.

(b) Approvals shall be in writing, served on the applicant.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(a), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2196.3. Disapproval.

(a) The Commissioner may disapprove any policy or bond forms which are unfair, unreasonable, or otherwise inconsistent with the provisions of the Insurance Code.

(b) If the Commissioner reviews an application and determines that the application should be disapproved, the Commissioner shall issue a Notice of Determination to Hold Hearing. A Notice of Determination to Hold Hearing shall set forth the basis for disapproval.

(c) Within fifteen days of service of a Notice of Determination to Hold Hearing, an applicant must elect to either

(1) modify, supplement, amend or withdraw the application,

(2) acknowledge receipt of the notice and request a hearing pursuant to section 2197.1, or

(3) waive the right to a hearing and accept the disapproval. All elections must be written and filed. An applicant who fails to so elect will be deemed to have requested a hearing.

(d) Absent good cause, hearings shall ordinarily commence within 45 days of service of a request for hearing. The time period set forth in this section is directory, not mandatory.

(e) Service of a Notice of Determination to Hold Hearing shall constitute an act by the Commissioner on the policy or bond form application. No policy or bond form application shall be deemed approved after a Notice of Determination to Hold Hearing has been served.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4– 90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).
4. Editorial correction of printing error in subsection (b) (Register 91, No. 46).

§ 2196.4. Revocation of Approval.

(a) Approval of a policy or bond form application may be revoked for good cause, after a hearing is held as set forth in article 3 of this subchapter. Good cause to revoke approval shall include forms that by their contents or as utilized are unfair, unreasonable or otherwise inconsistent with the provisions of the Insurance Code.

(b) Revocations of approvals shall be in writing, served on the applicant.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.5(a) and (b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

Article 3. Hearing Procedures

§ 2197.1. Definitions.

In addition to the definitions set forth in section 2195.2, the following definitions shall apply:

(a) "Certificate of Service" means a statement, signed under penalty of perjury under the laws of California by a person at least 18 years of age and not a party to the proceeding, containing the names and addresses of all parties to the proceeding, indicating the date, place and manner of service to all parties to the proceeding of the pleading or other document a copy of which is attached. An employee of a party may sign a certificate of service.

(b) "Day" means a calendar, not business day.

(c) "Pleading" means any petition, notice of defense, withdrawal of application, waiver of hearing, notice of hearing, notice of determination to hold hearing, acknowledgement of notice of determination to hold hearing and request for hearing, petition to intervene, any motion or other formal filing made as part of a proceeding held pursuant to this subchapter. An application is not a pleading.

(d) "Proceeding" means any hearing conducted pursuant to Insurance Code section 1855.5.

(e) "Filing Office" means that office within the office of the Insurance Commissioner in San Francisco, designated for receipt of all pleadings filed pursuant to this subchapter. Facsimile transmissions and plastic bound documents shall not be submitted to the Filing Office.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2197.2. Procedural Requirements.

(a) Form and Size. Pleadings and other documents submitted pursuant to this subchapter other than applications shall be typewritten or printed on paper 8–1/2 inches wide and 11 inches long. Exhibits annexed thereto shall be folded to the same size. Unless preprinted, the impression shall be on one side of the paper only and shall be double–spaced, except that footnotes and quotations in excess of a few lines may be single–spaced. Pages of documents shall be consecutively numbered and fastened together without cover in any suitable manner other than plastic binding. Reproduction may be by any process, except facsimile machine, provided that all copies are clear and legible.

(b) Title and File Number. The first page of any document submitted for filing shall show the full name, mailing address and telephone number of the person submitting it or that person's attorney, if any, the caption of the proceeding, the Department proceeding number (if assigned), and the title of the document. Sufficient space in the upper right–hand corner shall be left blank for a date stamp.

Documents initiating new proceedings shall have a blank space for the Department to insert the proceeding number.

A Sample form appears in article 16 of subchapter 4.5, section 2630.2.

(c) Signatures. The original of each pleading shall be signed in ink by each person or their attorney. If the person is a corporation or association, the document shall be signed by an officer. any attorney for or other representative shall show his or her address and telephone number.

(d) Verification. Petitions, answers, notices of defenses or amendments thereto shall be verified. If the party filing such pleadings is a corporation or association, the pleading must be verified by and officer.

Verification may be made before a notary public or by declaration under penalty of perjury under California law.

A sample verification form appears in article 16 of subchapter 4.5, sections 2630.9 – 2630.11.

(e) Signature and Verification by Attorney. The attorney for a party may sign and verify any pleading if the party is absent from the county where the attorney's office is located, or for some other reason is unable to sign and verify the pleading. When a pleading is signed and verified by an attorney, the attorney shall set forth in a declaration the reasons why the verification is not made by the party.

(f) Service of Pleadings. Whenever a pleading or other document is filed with the Insurance Commissioner, a certificate of service shall be attached thereto, indicating the date a copy was served on all other parties. The original certificate shall be submitted to the Insurance Commissioner and shall include a list of the name and addresses of the persons served.

A sample certificate of service form appears in article 16 of subchapter 4.5, section 2630.12.

(g) Copies. Unless otherwise required by the Insurance Commissioner, there shall be filed with the Insurance Commissioner an original and four copies of each pleading or other document other than an application, filed pursuant to this subchapter.

(h) Amended Pleadings. Amended pleadings may be filed provided they are served upon all parties at least 10 days before the hearing. Thereafter, pleadings may be amended as permitted or directed by the hearing officer.

(i) Place of Filing. Unless otherwise directed, all pleadings and other documents other than applications filed pursuant to this subchapter shall be filed with the Filing Office in San Francisco.

(j) Rejection of Documents. Pleadings which are not in substantial compliance with applicable statutes, these regulations, or an order of the Insurance Commissioner or hearing officer, may be rejected. When pleadings and other documents submitted for filing pursuant to this subchapter are rejected, the sender will be provided with the reasons for the rejection. Acceptance of a document for filing is not a determination that the document complies with all requirements and is not a waiver of those requirements. The Insurance Commissioner may require amendment of a document.

(k) Acknowledgements. Any person who desires an acknowledgment by the Insurance Commissioner of the filing of a document he or she has submitted must so request and must furnish, at the time of submission, an extra copy of the letter of transmittal or of the document, and a self-addressed envelope with postage fully prepaid. Upon filing, the extra copy will be stamped and returned by mail to the requesting party.

(*l*) Computation of Time. The time within which any document other than an application may be served or filed as provided by any statute, regulation, or direction of the Insurance Commissioner or a hearing officer shall be computed so as to exclude the first day and include the last day; provided, that when the last day of any such period falls on Saturday, Sunday or holiday under the laws of this State, the computation of time shall omit that day and include the first "business" day thereafter. When service is made by mail, the provisions of California Code of Civil Procedure section 1013 shall apply. When the service is made by personal delivery, the provisions of California Code of Civil Procedure section 1011 shall apply.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order including amendment to subsections (b), (d) and (f) transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2197.3. Decision to Hold Hearing.

The Insurance Commissioner shall exercise discretion in deciding whether or not to hold a hearing under Insurance Code section 1855.5. The Commissioner will serve a Notice of Determination to Hold Hearing if he or she reviews an application and determines that it should be disapproved.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2197.4. Notice of Hearing.

Written notice of not less than 10 days shall be given to the applicant prior to commencement of any hearing.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

Article 4. Consumer and Interested Party Participation

§ 2198.1. Intervention Right.

Any consumer representative or other interested person may intervene in any hearing under this subchapter unless it is determined by the hearing officer that granting the petition to intervene will unduly broaden the issues or would unduly burden resolution of the hearing.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4– 90 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 2–4–91 as an emergency operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).
4. Editorial correction of punctuation printing error in NOTE (Register 91, No. 46).

§ 2198.2. Consumer Representatives.

For purpose of this subchapter, "Consumer Representative" means anyone who, in the judgment of the Commissioner or Hearing Officer, represents the interests of the public, policyholders, claimants or any other interest not otherwise adequately represented.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2198.3. Interested Parties.

"Interested party" means any person, organization, association or other entity that believes it has an interest in the hearing.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2198.4. Procedures for Intervention.

An interested party or consumer representative desiring to intervene and become a party to the hearing shall file a petition to intervene which shall be drafted in compliance with section 2197.2 of this subchapter.

The Petition to Intervene shall contain the grounds of the proposed intervention, the positions and interest of the petitioner in the proceeding, and whether the petitioner supports or opposes the application which is the subject of the hearing.

A petition to intervene shall be filed with the Commissioner and served prior to the hearing, except for good cause shown.

The Commissioner or hearing officer shall rule on the petition.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 2–4–91 order including amendment transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

§ 2198.5. Other Participation.

In the discretion of the Hearing Officer, consumer representatives and other interested persons who have not formally intervened may participate in the hearing in any other manner the hearing officer deems appropriate under the circumstances.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 2–4–91 order transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

Article 5. Public Access to Submitted Documents

§ 2199.1. Public Inspection.

All applications and other documents submitted pursuant to this subchapter shall be available for public inspection at the Commissioner's Office in Los Angeles and San Francisco.

NOTE: Authority cited: Section 12921, Insurance Code; and *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.5(b), Insurance Code; Section 6256, Government Code.

HISTORY

1. New section filed 10–5–90 as an emergency; operative 10–5–90 (Register 90, No. 45). A Certificate of Compliance must be transmitted to OAL by 2–4–90 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 2–4–91 as an emergency; operative 2–4–91 (Register 91, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–4–91 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 2–5–91 order including amendment transmitted to OAL 5–17–91 and filed 6–17–91 (Register 91, No. 36).

Subchapter 1.6. Advisory Organizations, Manuals Approval

Article 1. Submission and Approval Procedures, Fees

§ 2199.2.1. Preamble.

Section 1855.1 of the California Insurance Code states that the Legislature intended to promote competition in the insurance business and provide a means whereby insurance customers can more easily comparison shop for insurance coverage by allowing advisory organizations to develop and draft for use by insurers in California common forms, coverages, endorsements and manuals. Section 1855.5 provides that the Commissioner shall approve only those manuals that are found by him or her to contemplate activities and practices that are not unfair, unreasonable or otherwise inconsistent with the insurance code. The Insurance Commissioner promulgates these regulations in order to:

(1) interpret the provisions of Insurance Code section 1855.5 as applied to manuals, and

(2) interpret the provisions of Insurance Code sections 1855.4 and 1861.03 as applied to manuals with respect to the application of the terms "unfair, unreasonable or otherwise inconsistent with the provisions of this code" in Insurance Code section 1855.5.

NOTE: Authority cited: Section 12921, Insurance Code; Calfarm Insurance Company, et al. v. Deukmejian, et al, 48 Cal. 3d 805, 824 (1989); and 20th Century v. Garamendi, 8 Cal.4th 216 (1994). Reference: Sections 1855.1 through 1855.5, Insurance Code.

HISTORY

1. New subchapter 1.6 (articles 1–4), article 1, (sections 2199.2.1—2199.2.8) and section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.2. Authority and Scope.

This subchapter is promulgated pursuant to Insurance Code Sections 1855.1 through 1855.5. This subchapter shall only apply to advisory organizations and shall not be construed to require or permit advisory organizations to submit any documents to the Department of Insurance not provided for in the Insurance Code, or other Subchapters of the California Code of Regulations.

NOTE: Authority cited: Section 12921, Insurance Code; Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824; and 20th Century v. Garamendi, 8 Cal. 4th, 216 (1994). Reference: Sections 1855.1 through 1855.5, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.3. Findings.

For purposes of these regulations, the Commissioner finds that:

(a) According to custom and usage in the insurance industry, a manual is a publication distributed by an insurer to its agents and policy issuance personnel for purposes of instructing them on how to assemble an insurance policy. Typically, such manuals include one or more types of material such as policy writing rules, rating plans, classification codes, and descriptions, territory codes and descriptions, rules that include factors and relativities, prospective cost information or rates.

(b) Advisory organization manuals made available to insurers in many other states include prospective loss costs.

(c) Insurance Code section 1855.5 authorizes advisory organizations to prepare, develop and file manuals, but prohibits advisory organizations from issuing any manual that contains final rates.

(d) Insurance Code section 1855.5 requires that the Commissioner approve only those advisory organization manuals that are found by him or her to contemplate activities and practices that are not unfair, unreasonable or otherwise inconsistent with the provisions of the Insurance Code.

(e) Under Insurance Code section 1855.5 as well as California case law, the Commissioner has the authority to determine and regulate the competitive effect of the advisory organization manuals within the context of insurance practices that may be unfair, unreasonable or otherwise in violation of the insurance code.

(f) Where there is a large number of insurers, an unconcentrated market structure, shifting market shares, or a real potential for the entry and exit of insurers, the property/casualty insurance markets in the United States and California for any line of insurance is likely to be competitively structured and competitive.

(g) In other states, evidence of price differentials in the form of filed statewide rate levels of insurers that use advisory organization manuals in competitively structured insurance markets indicates that the availability of advisory organization manuals has not, to date, adversely affected competition.

(h) The law in other states, including the law regarding the applicability of antitrust law to the business of insurance, may or may not be the same as it is in California.

(i) The availability of advisory organization manuals usually provides economies of scale in the production of actuarial information and encourages the potential participation by small insurers as well as entry by insurers without prior experience or expertise in insurance markets. Because these economies of scale and potential participation promote competitive insurance markets, they should be encouraged, unless on balance they are found to have an anti–competitive effect.

NOTE: Authority cited: Section 12921, Insurance Code; Calfarm Insurance Company et al. v. Deukmejian, et al. 48 Cal. 3d 805, 824 (1989); and 20th Century v. Garamendi, 8 Cal. 4th 216 (1994). Reference, Sections 1855.1 through 1855.5, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.4. Definitions.

(a) "Advisory organization" means every group, association, or other organization of insurers, whether located within or outside of this state, that develops or prepares policy or bond forms or manuals, for use by admitted insurers, carries on research relative to the development and preparation of policy or bond forms, and acts in an advisory, as distinguished from a ratemaking, capacity, and has filed with the Commissioner (a) a copy of its constitution, articles of incorporation, agreement of association, and of its by– laws, or rules and regulations governing its activities. (b) a list of its members and subscribers, and (c) the name and address of a resident of this State upon whom notices or orders of the Commissioner or process may be served.

(b) "Applicant" means any advisory organization as defined in this subchapter applying for approval of a manual pursuant to California Insurance Code Section 1855.5.

(c) "Application" means the transmittal letter and manual and other documentation which every advisory organization seeking approval of a manual pursuant to California Insurance Code Section 1855.5(a) must file with the Rate Regulation Division, Rate Filing Bureau.

(d) "Transmittal Letter" means the correspondence accompanying the manual filed for approval. Every transmittal letter shall comply with the requirements of Section 2199.2.6(b).

(e) "Submission" means acceptance for review of a filed application by the Rate Regulation Division, Rate Filing Bureau. The date of submission shall be the date an application is accepted for review pursuant to Section 2199.3.1.

(f) "Manual" means any publication, which is developed or prepared by an advisory organization or any revisions thereof, that could include one or more types of material such as policy writing rules; rating plans; classification codes and descriptions; territory codes and descriptions; rules that include factors or relativities, such as increased limits factors, classification relativities or similar factors, or prospective cost information.

(g) "Market" means the entire statewide business of insurance in California for the Annual Statement Statutory Page 14 line or lines of business under which premium is reported for any type of insurance that is the subject of the advisory organization manual. The market includes all insurers that, by virtue of holding a certificate of authority issued by the Commissioner under Cal. Ins. Code section 700, are entitled to transact any such line or lines of insurance business in California as well as those that are actually writing such insurance.

(h) "Technical or actuarial requirements" means all grounds in the California Insurance Code, other than competitive grounds, upon which the Commissioner is authorized to base his or her review, approval and/or disapproval of advisory organization manuals.

(i) "Party" means the advisory organization whose manual is the subject of a proceeding under this regulation; any person whose petition to intervene in the proceeding has been granted pursuant to section 2661.1 of these regulations; or the California Department of Insurance.

NOTE: Authority cited: Section 12921, Insurance Code; Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824; and Pasadena Police Officers Association v. City of Pasadena, 51 Cal.3d 564 (1990). Reference: Sections 100, 1855.1, 1855.2, 1855.3, 1855.5 and 12973.9, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.5. Fees.

(a) A one hundred dollar ($100) fee shall be paid at the time an application is filed for submission.

(b) Applications which are not accompanied by the appropriate fee shall be rejected.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Sections 1855.5 and 12973.9, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.6. Filing Requirements.

All manuals developed or prepared by an advisory organization, shall be filed with the California Department of Insurance, Rate Regulation Division, Rate Filing Bureau, 45 Fremont Street, 23rd Floor, San Francisco, California 94105, in compliance with the following standards:

(a) All manuals shall be filed with a transmittal letter.

(b) Every transmittal letter shall include the following information:

(1) Name and address of advisory organization

(2) Name, address and telephone number of contact person

(3) Title of the manual submitted

(4) A general description of the manual submitted

(5) Whether the manual revises a manual previously filed with or approved by the Commissioner, and if so. identifying the manual.

(c) All filings shall include the fee set forth in section 2199.2.5.

(d) All filings shall include an original and three (3) copies of the application. Any person desiring an acknowledgment of the filing of an application must so request in their transmittal letter and must furnish an extra copy of the application together with a self–addressed envelope with postage fully prepaid.

(e) Applications filed pursuant to this subchapter shall be typewritten or printed on paper 8–1/2 inches wide and 11 inches except that exhibits annexed thereto of a larger size shall be folded to the 8–1/2 inches wide and 11 inches long size. Unless pre–printed, the impression shall be on one side of the paper only. Pages of documents shall be consecutively numbered and fastened together in any suitable manner except plastic binding. Reproduction may be by any process, except facsimile machine, provided that all copies are clear and legible.

(f) All proposed manual(s) must be submitted in an easily readable condition. Printer's proofs, typewritten or photostatic copies, or other legible copies, other than by facsimile transmission, will be accepted. Plastic bound documents will not be accepted.

(g) Any employee of an advisory organization may submit an application on behalf of an advisory organization, provided that the transmittal letter is on the advisory organization's letterhead and is signed in ink and indicates the name and title of the employee.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal.3d 805, 824. Reference: Sections 1855.2 and 1855.5(a), Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.7. Information Requirements.

(a) Each application shall include the following, if applicable:

(1) if the application relates to a new program or line of business, the applicant shall provide a written explanation of the purpose and intent of the new manual;

(2) if the application is a revision or replacement of a previously approved manual, the application must describe each revision or replacement and the reasons for each revision or replacement, and must include copies of the revised or replaced manual;

(3) information in support of applicant's claim that the manual is technically correct and will not have an adverse effect on competition;

(b) Any information required by section 2199.2.7(a) may be included in the transmittal letter or in a separate memorandum. If provided in a separate memorandum, the memorandum shall be attached to the transmittal letter.

(c) Applicants shall be required to provide such additional information as the Commissioner may require for purposes of review.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Sections 1855.2 and 1855.5(a), Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.2.8. Service and Computation of Time.

Whenever a writing is due from the Commissioner, an applicant or any other person, it shall be served in accordance with the procedures set forth in sections 2651.1–2660.1 of these regulations.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

Article 2. Actions on Approval

§ 2199.3.1. Review of Applications.

(a) The Insurance Department shall review any submitted application to determine whether or not the application complies with applicable procedural requirements and whether or not the manual contents or the use thereof would be inconsistent with the Insurance Code or would result in activities and practices by insurers that are unfair, unreasonable or otherwise inconsistent with the Insurance Code.

(b) Within fifteen days of receipt by the Department, applications which do not meet the requirements of sections 2199.2.6 and 2199.2.7 may be rejected. A rejection shall constitute an act by the Commissioner on the manual application and no application that has been rejected shall be deemed approved. In the case of a rejection, the Commissioner shall notify the applicant in writing of the reason(s) for the rejection. Acceptance of an application is not a determination that the application complies with all requirements and shall not constitute a waiver of any requirements.

(c) The Commissioner may allow or require an applicant to modify, supplement, or amend an application.

(d) A rejection shall be effective on the date it is served.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Section 1855.5(a) and (b), Insurance Code.

HISTORY

1. New article 2 (sections 2199.3.1—2199.3.6) and section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.3.2. Approval of Applications.

(a) Reviewed applications shall be approved if the Commissioner determines that the manual or manual contents or the use thereof would be consistent with the Insurance Code and would not result in activities and practices by insurers that are unfair, unreasonable or otherwise inconsistent with the Insurance Code.

(b) Approvals shall be in writing, served on the applicant. No manual may be distributed for use in writing risks located in California until it has been approved. Approval of a manual shall remain in effect until such time as such approval is revoked pursuant to section 2199.3.4 of these regulations.

(c) After a manual has been approved, if it is revised, the revised pages must be submitted for the Commissioner's review and approval. The revised pages may not be distributed for use in writing risks located in California until they have been approved by the Commissioner. If approval of the revised pages is denied, such denial will not affect the status of the remaining portion of the manual. The same standards and procedures which apply to approval of a manual and hearings related to the disapproval of a manual, will apply to determinations regarding revised pages.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Sections 1855.4 and 1855.5(a), Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.3.3. Disapproval.

(a) The Commissioner shall disapprove any manual which is found by him or her to contemplate activities and practices that are unfair, unreasonable, or otherwise inconsistent with the provisions of the Insurance Code. A manual shall not be disapproved as contemplating activities and practices that are unfair, unreasonable or otherwise inconsistent with the Insurance Code based on technical or actuarial grounds unless the manual fails to meet the requirements of section 2199.3.5. A manual shall not be disapproved as contemplating activities and practices that are unfair, unreasonable or otherwise inconsistent with the provisions of the Insurance Code based on the grounds of an adverse effect on competition unless the requirements of section 2199.3.6 are met.

(b) If the Department of Insurance reviews an application and determines that the application should be disapproved, the Commissioner shall issue a Notice of Determination to Hold Hearing. A Notice of Determination to Hold Hearing shall set forth the basis for disapproval.

(c) Within fifteen days of service of a Notice of Determination to Hold Hearing, an applicant must elect to either: (1) modify, supplement, amend or withdraw the application; (2) acknowledge receipt of the notice and request a hearing pursuant to section 2199.4.4 or (3) waive the right to a hearing and accept the disapproval. All elections must be written and filed. An applicant who fails to so elect will be deemed to have requested a hearing.

(d) Absent good cause, hearings shall commence within 60 days of service of a request for hearing. Hearings shall be conducted in accordance with the provisions of Insurance Code section 1861.08 and sections 2649.1 – 2662.8 of these regulations.

(e) At all such hearings, the applicant shall have the burden of proving that the manual does not contemplate activities and practices that are unfair, unreasonable, or otherwise inconsistent with the provisions of the Insurance Code.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Sections 1855.4 and 1855.5(b),1861.08, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.3.4. Revocation of Approval.

(a) Approval of a manual may be revoked for good cause after a hearing. Good cause to revoke approval shall be only on the same grounds and conditions which would permit disapproval if the manual were submitted for approval at the time of hearing. The hearing shall be conducted in accordance with the provisions of Insurance Code section 1861.08 and sections 2649.1 – 2662.8 of these regulations.

(b) Revocations of approval shall be in writing, served on the applicant.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian (1989) 48 Cal. 3d 805, 824. Reference: Sections 1855.4 and 1855.5(a), Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.3.5. Standards for Technical or Actuarial Review of Manuals.

A manual shall not be found to contemplate activities or practices that are unfair, unreasonable or otherwise inconsistent with the provisions of the Insurance Code based on the grounds that the contents of the manual fails to meet technical or actuarial requirements unless:

(a) the manual contents violate any provision of the Insurance Code, or

(b) the actuarial analyses underlying the contents of the manual are not actuarially sound according to the standards contained in the Statement of Principles Regarding Property and Casualty Insurance Ratemaking of the Casualty Actuarial Society (CAS) or other generally accepted actuarial standards.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.3.6. Standards for Review of Manuals' Effect on Competition.

(a) Absent a finding of an agreement by insurers to adhere to the manual as described in paragraph (c), an applicant shall be deemed to have met its burden of proving that a manual does not contemplate activities or practices that are unfair, unreasonable or otherwise inconsistent with the Insurance Code based on the grounds of an adverse effect on competition by presenting evidence sufficient to show that:

(1) the statewide market concentration, as measured by the Herfindahl–Hirschman Index, of all insurers licensed to write the lines of insurance for such market (using the statewide total written premium for the applicable lines of business as reported on the Annual Statement Statutory Page 14 for the most recently available calendar year) is less than 1000; or

(2) if the statewide market concentration of all insurers exceeds the standard set forth in 2199.3.6(a)(1) the statewide market concentration of insurers authorized to use the advisory organization manual (as demonstrated by records of the advisory organization submitted to the Commissioner), as measured by the Herfindahl–Hirschman Index (using the statewide total written premium for the applicable lines of business as reported on the Annual Statement Statutory Page 14 for the most recently available calendar year), for such insurers is less than 1000.

(b) If the applicant has met its burden of proof on this issue by showing that statewide market concentrations of all insurers or insurers authorized to use the advisory organization manual satisfy either of the standards of 2199.3.6(a)(1) or 2199.3.6(a)(2) any party claiming that the manual has an adverse effect on competition has the burden of proving this issue with evidence which would be sufficient for a plaintiff to establish that the distribution and use of the manual in the market as defined in section 2199.2.4(g) of this regulation is anticompetitive in violation of the California antitrust laws. In determining whether such party has met its burden of proof on that issue, the Commissioner shall consider the standards of sections 2199.3.6(a)(1) and 2199.3.6(a)(2) of this regulation and any and all other relevant evidence including but not limited to:

(1) the existence of significant variation in insurers' statewide filed rate levels in effect for the applicable lines of insurance with respect to insurers authorized to use the manual over the last three calendar years; and

(2) the existence of significant change in statewide market shares (using the Annual Statement Statutory Page 14 written premium of insurers for the applicable lines of insurance) over the last ten calendar years; and

(3) the entries and exits of insurers measuring one–tenth of one percent of the market (using the Annual Statement Statutory Page 14 written premium of insurers for the applicable lines of insurance) over the last ten calendar years; and

(4) whether one or more insurers, alone or in conjunction with each other, control the business of the advisory organization, or decide or determine the contents of the advisory organization manual according to the documents governing the operation of the advisory organization that have been submitted to the Commissioner.

(c) A manual may be found to contemplate activities or practices that are unfair, unreasonable or otherwise inconsistent with the Insurance Code on the grounds of an adverse effect on competition if the Commissioner determines that there is an agreement to adhere to the manual as prohibited by section 1855.4 of the Insurance Code, which is supported by direct evidence. However, pursuant to section 1855.4 of the Insurance Code, the following shall be insufficient evidence, alone or taken together, to establish an agreement to adhere to the manual:

(1) the fact that two or more insurers participate in the activities of the advisory organization submitting the manual;

(2) the fact that two or more insurers use or may use, either consistently or intermittently, the manual or other manuals of the advisory organization; or

(3) the fact that the advisory organization manual contains information authorized by statute or regulation.

(d) The Commissioner can, by regulation, at any time, change the standards set forth in section 2199.3.6(a)(1) and 2199–3.6(a)(2). He or she can change the specified Herfindahl–Hirschman Index to a different index or change the 1000 score on that or any other index after considering evidence that some other index or some other point on this index is a better measurement of the degree of competition.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

Article 3. Hearing Procedures

§ 2199.4.1. Definitions.

In addition to the definitions set forth in section 2199.2.4, and except for the definition of "Proceeding" set forth herein, the definitions contained in section 2651.1 of these regulations shall apply to hearings held pursuant to this subchapter regarding the disapproval of advisory organization manuals:

(a) "Proceeding" means any hearing conducted pursuant to Insurance Code section 1855.5, which shall be conducted in accordance with the provisions of Insurance Code section 1861.08 and these regulations.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New article 3 (sections 2199.4.1—2199.4.4) and section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.4.2. Procedural Requirements.

With the exception of the requirements which follow, all procedural and evidentiary requirements in hearings regarding advisory organization manuals shall conform with the requirements of sections 2650.1 – 2659.4 of these regulations.

(a) Copies.

Unless otherwise required by the Insurance Commissioner, an original plus four copies of each pleading or other document, including the application, filed pursuant to this subchapter shall be filed with the Commissioner.

(b) Place of Filing.

Unless otherwise directed, all pleadings and other documents other than applications filed pursuant to this subchapter shall be filed with the Administrative Law Bureau, California Department of Insurance, 45 Fremont Street, 22nd Floor, San Francisco, CA 94105.

Applications and manuals submitted for review shall be submitted to California Department of Insurance, Rate Regulation Division, Rate Filing Bureau, 45 Fremont Street, 23rd Floor, San Francisco, California 94105.

(c) Rejection of Documents.

Pleadings which are not in substantial compliance with applicable statutes, these regulations, or an order of the Insurance Commissioner or Administrative Law Judge, may be rejected. When pleadings and other documents submitted for filing pursuant to this subchapter are rejected, the sender will be provided with the reasons for the rejection. Acceptance of a document for filing is not a determination that the document complies with all requirements and is not a waiver of those requirements. The Commissioner may require amendment of a document.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al, (1989) 48 Cal. 3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.4.3. Decision to Hold Hearing.

The Insurance Commissioner shall exercise discretion in deciding whether or not to disapprove a manual and serve a Notice of Determination to Hold Hearing pursuant to section 2199.3.3 of these regulations because it fails to meet the requirements of Insurance Code section 1855.5. The Commissioner will serve a Notice of Determination to Hold Hearing when he or she reviews an application and determines that it should be disapproved or revoked. Hearings shall be conducted in accordance with the provisions of Insurance Code section 1861.08 and sections 2649.1 – 2662.8 of these regulations.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al. (1999) 48 Cal. 3d 805, 824. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

§ 2199.4.4. Notice of Hearing.

If applicant acknowledges receipt of the Notice of Determination to Hold Hearing and requests a hearing, the Department shall serve written notice of hearing not less than 10 days prior to the first scheduled appearance for any such hearing.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et al. v. Deukmejian, et al, (1989) 48 Cal. 3d 805, 814. Reference: Section 1855.5, Insurance Code.

HISTORY

1. New section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

Article 4. Consumer and Interested Party Participation

§ 2199.5.1. Intervention.

Intervention in any proceeding having to do with an advisory organization manual shall be pursuant to sections 2661.1 – 2662.8 of these regulations.

NOTE: Authority cited: Section 12921, Insurance Code; and Calfarm Insurance Company, et. al. v. Deukmejian, et al. (1989) 48 Cal. 3d 805, 824. Reference: Section 1855.5(b), Insurance Code.

HISTORY

1. New article 4 (section 2199.5.1) and section filed 6–26–96; operative 7–26–96 (Register 96, No. 26).

Subchapter 2. Policy Forms and Other Documents

Article 1. Document Submission and Approval Procedures; Fees

§ 2200. Authority.

NOTE: Authority and reference cited: Sections 779.8, 779.13, 795.5, 1320, 9080.1, 10191, 10205, 10225, 10270.1, 10270.2, 10270.3, 10270.5, 10270.57, 10270.9, 10270.93, 10271, 10290, 10292, 10506, 10507.2, 11027, 11029, 11066, 11069, 11512.4, 11513, 11522, 11658, 11659, 12250, 12763, 12973.9, California Insurance Code and Sections 2249.2, 2249.5, 2266, 2529, California Administrative Code, Title 10.

HISTORY

1. Repealer and new Article 1 (Sections 2200–2218.1) filed 10–4–79; designated effective 1–2–80 (Register 79, No. 40). Sections 2218.2–2218.10 of former Article 1.2 incorporated into Article 1. For prior history, see Registers 65, No. 16, 76, No. 46, 77, No. 19, 78, No. 4 and 78, No. 34.
2. Repealer filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2201. Definitions.

As used in this Article:

(a) "Document" includes but is not limited to every form of contract, insurance policy, application, enrollment form, rider, endorsement, amendment, insert policy page, certificate or other evidence or notice of insurance, fill–in material, text cell, schedule of rates and classification of risks except for workers' compensation insurance, advertisement and any modification thereto which is required by law to be filed or approved and which pertains to coverages defined in Ins. C. §§ 101, 106 and 109.

(b) "Fee" means the fee charged by the Commissioner for the filing or approval of documents subject to this Article.

(c) "Application" means a document used to apply for or request individual or group insurance coverage which contains medical or economic questions designed to determine the rating class or the eligibility for coverage of one or more persons and which is not an "enrollment" form. This definition shall not apply to "application" as it may be used in any other statute or regulation.

(d) "Enrollment Form" means a document used to apply for or request individual or group insurance coverage which contains no questions about an individual's health status or eligibility for coverage except that it may inquire about age, family status, dependency or current or past employment. A document to be used by a master–policy–holder to apply for or request group insurance is an "enrollment form" for the purposes of these regulations, provided that no information concerning the health of any persons to be covered is solicited. This definition shall not be used to interpret the word "application" as it may be used in any other statute or regulation.

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(e) "Rider/insert page" means a document of one or more pages of text, identified by a single form number, which is physically added to or inserted into another document, such as a policy, certificate, application or other rider.

(f) "Text cell" means a block of text not to exceed one paragraph in length, which is identified for filing purposes by a form number and which is printed with other similarly-identified blocks of text to comprise documents such as policies and certificates. A text cell exceeding one paragraph in length or a list of words or phrases to be inserted into a waiver rider is considered to be a "rider/insert page". Where multiple text cells are filed on a single page, the total fee for the cells on that page shall not exceed the fee for a rider/insert page.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506, 10704 and 12973.9, California Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 9080.1, 10112.5, 10163.3, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10489.93, 10506, 10705, 10717, 11027, 11029, 11066, 11069, 11522, 11658 and 12250, California Insurance Code.

HISTORY

1. Amendment of subsection (a), new subsections (c)-(f) and repealer and new NOTE filed 8-26-96 as an emergency; operative 9-3-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-2-97 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8-26-96 order, including amendment of NOTE, transmitted to OAL 12-27-96 and filed 2-11-97 (Register 97, No. 7).

§ 2202. Documents to Be Submitted; Fees.

(a) The fees to be charged for the Commissioner's actions on documents submitted to him are determined according to the document classes below. The fees for each document class are set forth in the Fee Table in subsection (b).

(1) ("Health Insurance") Group, blanket or individual documents that include benefits contingent on hospital confinement or on medical or surgical treatment of sickness or injury or on diagnosis of sickness, whether provided on a stipulated benefit, indemnity or reimbursement basis, except where described more specifically in another subdivision; disclosure material required by Ins. C. § 10270.3.

This class of documents:

(A) Includes documents which also provide coverages described elsewhere in this Section, such as group documents providing life insurance in addition to "health" insurance coverage.

(B) Includes rates and risk classifications for individual "health" insurance policies.

(C) Includes small employer health insurance rating plans; lists of small employer health insurance benefit plan designs; lists of associations to which or through which small employer health insurance benefit plans are marketed and information pertaining thereto.

(D) Does not include documents providing only dental and/or vision coverage or documents providing only coverage for treatment of accidental injuries unless they are included with filings of documents that are not so limited.

(E) Does not include documents providing stop-loss coverage to self-insured plans or to providers in capitated plans.

(2) ("Group and Blanket Life and Non-health Disability,") Blanket life and group life documents. Blanket disability, tuition refund and group disability documents, except where described more specifically in another subdivision. Documents providing stop-loss coverage to self-insured plans or to providers in capitated plans.

(3) ("Individual Disability, Non-health") Individual disability documents and rates and risk classifications therefor, except where described more specifically in another subdivision.

(4) ("Medicare Supplement")

(A) Group or individual documents providing Medicare supplement coverage.

(B) Documents advertising Medicare supplement coverage.

(C) Rate filings and filings of experience under previously-approved Medicare supplement insurance rate schedules demonstrating compliance with loss ratio standards for in-force policies.

(D) Other filings with the Commissioner related to the marketing or rating of Medicare supplement insurance as required by law.

(5) ("Long-term Care")

(A) Group or individual documents providing "long-term care insurance" as defined in Ins. C. § 10231.2.

(B) Rates and risk classifications for individual policies.

(C) Documents demonstrating compliance with Ins. C. §§ 10231.6(c) and 10232(b).

(D) Documents advertising long-term care insurance.

(E) Other filings with the Commissioner related to the marketing or rating of long-term insurance as required by law.

(6) ("Credit Life and Disability")

(A) Credit life and/or disability documents which are non-standard or are required to be approved pursuant to §§ 2249.2 or 2249.5 of this Chapter.

(B) Voluntary downward deviated rates; renewal of previously-approved upward deviated rates and actuarially equivalent rates; upward deviated rates and mandatory downward deviated rates.

(7) ("Supplemental Life Benefits") Individual life or individual or group annuity documents with provisions which:

(A) Provide additional benefits in the case of death by accident or operate to safeguard such contracts against lapse, give a special surrender value, special benefit or an annuity if the insured or annuitant becomes disabled.

(B) ("Accelerated Benefits") Accelerate the payment of life insurance benefits on an annuity or lump-sum basis or waive annuity surrender or withdrawal charges contingent upon the life insured's or annuitant's catastrophic injury or illness. Applications reflecting any additional underwriting criteria for issue of such provisions.

(C) Provide long-term care benefits funded by reducing life insurance benefits otherwise payable or by waiving annuity withdrawal charges. Applications reflecting any additional underwriting criteria for issue of such provisions.

(8) ("Variable Life and Annuities") Group and individual variable annuity documents. Group and individual variable life insurance documents.

(9) ("Fraternals") Fraternal benefit society disability documents except where described more specifically in another subdivision.

(10) Workers' compensation insurance forms. Workers' compensation rates shall be filed as provided for in § 2509.30. et seq, of this Chapter.

(11) Every document, including documents attached thereto or incorporated therein, which pertains to coverages defined in Ins. C. §§ 101, 106 and 109, which is required to be approved or filed and for which no fee is otherwise provided.

(12) ("Universal Products") Documents providing individual life insurance with indeterminate premiums or other values. Individual annuities and group annuity certificates with indeterminate contributions or other values. Filings of these documents are exempt from §§ 2203, 2205 and 2208 through 2218.10.

(13) ("Grants and Annuities") Annuity contracts of grants and annuities societies. See Ins. C. § 11522 to compute fees for more than 10 documents filed within a calendar quarter. Filings of these documents are exempt from §§ 2203, 2205 and 2208 through 2218.10.

(14) ("Reciprocal or Inter-insurance Exchanges")

(A) Powers of attorney and amendments and revisions thereto of reciprocal or inter-insurance exchanges. Filings of these documents are exempt from §§ 2203, 2205 and 2208 through 2218.10.

(B) Documents required to be filed with the Commissioner under subdivisions (b), (c) and (d) of Ins. C. § 1320 shall be subject to these regulations as if they were being submitted by stock insurers.

(15) Articles of incorporation, constitutions and by–laws of fraternal benefit societies and amendments thereto or revisions thereof. Filings of these documents are exempt from §§ 2203, 2205 and 2208 through 2218.10.

(16) Motor club service contracts: Original service contract, including application and membership card. (See Ins. C. § 12168 for fees for amended contracts, applications and membership cards.) Filings of these documents are exempt from §§ 2203, 2205 and 2208 through 2218.10.

(b) Fee Table:

Subdivision of § 2202(a)	*Policy*	*Certificate*	*Rider/ Insert Page*	*Text Cell*	*Application*	*Enrollment Form*	*New Issue Rates*	*Rate Increases**	*See Note Below*	*Other Forms*
(1)	$580	$290	$130	$30	$180	$30	$130	$170	1	$130
(2)	330	170	60	30	130	30	NA	NA		60
(3)	580	NA	130	30	130	30	130	170		130
(4)	330	170	60	30	130	30	130	130	2	60
(5)	580	290	130	30	180	30	130	170	3	130
(6)	170	170	80	30	130	30	*See Note 4*			80
(7)	(A): 60		(B): 60		(C): Documents: 200; Applications: 180					60
(8)	330	170	60	30	130	30	NA	NA		60
(9)	NA	420	100	30	100	30	NA	NA	5	100
(10)	130	30	30	30	NA	NA	*See § 2509.30. et seq.*			30
(11)	60									
(12)	Individual Life Policies and Group Annuity Certificates: 340							Riders and Insert Pages: 90		
(13)	60 (See Ins. C § 11522 when more than 10 documents are filed within a calendar quarter.)									
(14)(A)	100									
(15)	50									
(16)	240									

NOTES	
*	Per experience group.
1	Small employer health insurance rating plans: $130 per submission. Lists of small employer health insurance benefit plan designs; lists of associations to which or through which small employer health insurance benefit plans are marketed and information pertaining thereto: $60 per list or amendment thereto.
2	Filings of experience under previously–approved Medicare supplement insurance rate schedules demonstrating compliance with loss ratio standards for in–force policies: $80 per experience group. Documents advertising Medicare supplement insurance. $60 per advertisement.
3	Documents demonstrating compliance with Ins. C. §§ 10231.6(c) and 10232(b). $100 per association. Documents advertising long–term care insurance. $60 per advertisement.
4	Voluntary downward deviated rates: $30 per experience group. Actuarially equivalent rates: $100 per experience group. Upward deviated rates and mandatory downward deviated rates: $200 per experience group. Renewals of previously–approved upward deviated rates and mandatory downward deviated rates: $100 per experience group.
5	Long–term care benefits funded by reducing life insurance benefits or by waiving annuity withdrawal charges: $200 per document. Applications with additional underwriting criteria for such long–term benefits; $180 per application.

(c) "Minimum Fee." A minimum fee of $80 shall be charged for each submission for which one Document Submission Form is included or for which one filing fee invoice is prepared.

(d) "Change of Company Name or Merger." Where an insurer changes its name or merges into another insurer and previously filed or approved documents are revised to reflect such name change or the name of the merger survivor (and address and company officers, as applicable) and no other changes whatsoever are made in such documents, the insurer or merger survivor shall submit a Document Submission Formset listing such documents in lieu of submitting the revised documents. The Document Submission Formset shall be accompanied by a cover letter signed by an executive officer of the insurer or merger survivor showing the previous approval dates of the documents and attesting that no changes have been made to them other than to the insurer's name (and address and company officers, as applicable). The fee shall be $100 per submission.

Previously filed or approved documents which are revised only to reflect a change in home office address or company officers need not be submitted.

(e) The Commissioner may increase or decrease the fees established in this Article by issuing a Bulletin setting forth the modified fees at least 90 days prior to their effective date. The Commissioner shall not issue more than one such Bulletin in a fiscal year. Any fee increases or decreases made pursuant to this subdivision shall be by a uniform percentage for all fees established in this Article rounded to the next ten dollars, except that the Commissioner may establish different uniform percentage changes for all documents described in subdivisions (1) through (11) of Section 2202(a), except for subdivision (4)(D); for all documents described in subdivisions (4)(D), (12) and (13) of Section 2202(a); or for all documents described in subdivisions (14) through (16) of Section 2202(a).

Any fee changes made pursuant to this subdivision shall not, in conjunction with other moneys received or projected to be received for the unit or units processing the documents subject to such fees, exceed the respective amounts calculated by the Department's Budget Office as necessary to cover all direct and indirect costs of the unit or units for the next succeeding fiscal year. Where moneys received or projected to be received for the unit or units processing the documents subject to such fees are insufficient to meet the respective amounts calculated by the Department's Budget Office as necessary to cover all direct and indirect costs of the unit or units during the then current fiscal year, any fee increases made during the then current fiscal year shall not, in conjunction with those moneys, exceed the amounts calculated by the Budget Office.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506, 10704 and 12973.9, California Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 9080.1, 10112.5, 10163.3, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10233.9, 10234.9, 10234.93, 10234.97, 10235.22, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10489.93, 10506, 10705, 10717, 11027, 11029, 11066, 11069, 11522, 11658 and 12250, California Insurance Code.

HISTORY

1. Amendment of subsections (a) and (b) filed 1-9-86; designated effective 2-2-86 pursuant to Government Code Section 11346.2(d) (Register 86, No. 2).
2. Amendment of section and repealer and new NOTE filed 8-26-96 as an emergency; operative 9-3-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-2-97 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 97, No. 7).
4. Certificate of Compliance as to 8-26-96 order, including amendment of section and NOTE, transmitted to OAL 12-27-96 and filed 2-11-97 (Register 97, No. 7).

§ 2203. Fee Computation Rules.

(a) The fee for a "policy" (including fraternal benefit society certificates) includes riders without which the policy could not be approved and applications, rates and risk classifications if required to be filed, but only if such documents are submitted before the authorization date of the policy. The fee for a group policy does not include fees for certificates. Fees for additional documents for use with a policy and submitted before the authorization date of the policy shall be charged separately. The fee charged for a "shell" policy also includes one insert page or set of insert pages which, together with the policy shell, comprises the simplest policy which the insurer intends to issue. Submitters of shell policies must stipulate which documents comprise the "simplest policy" to avoid being charged separately for each document.

(b) The fee for a revision of a document previously approved or filed by the Commissioner within 180 days of its submission shall be the lesser of the fee otherwise provided or $80 if the form is in substance the same as that previously acted upon, the only changes being minor ones to correct typographical errors or to make detailed language changes to meet the requirements of other jurisdictions.

(c) "Substantially Similar Documents." If the cover letter states that a document is substantially similar to another document in the filing or to a document previously filed with or approved by the Commissioner within one year for the same company or an affiliated company, and the document is found to be so, the fee shall be one half of the usual fee.

(d) "Simultaneous Filings by Affiliated Insurers." Where documents which are identical other than company name, address and officers, are submitted simultaneously by affiliated insurers and the cover letters so state, fees for one such insurer's submission shall be computed as otherwise provided and the greater of one half that amount or the minimum fee shall be charged for each other insurer's submission.

(e) Only one fee shall be charged for a document, regardless of the number of documents with which it will be used.

(f) The fee for a "wrap-around" group policy submitted at the same time as the certificate(s) which are incorporated by reference therein is one-half the fee otherwise provided for.

(g) Fees for submissions of all documents described in subdivisions (1) through (11) of Section 2202(a) shall be increased by 10 percent of their original amount for each time a submission is resubmitted following its second substantive rejection by the Commissioner. For the purpose of this subdivision, a new objection to text previously submitted as part of the filing shall not be a "substantive rejection" unless new text in the resubmission clarifies the previously submitted text so that it is now objectionable.

(h) Where a rate filing applies to multiple experience groups and the same rating methodology is applied to the rates for more than one such experience group, the fee for one experience group shall be computed as otherwise provided and the fee for each remaining experience group subject to that rating methodology shall be one-quarter of that for the first experience group.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506, 10704 and 12973.9, California Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 10717, 11027, 11029, 11066, 11069 and 11658, California Insurance Code.

HISTORY

1. Amendment of subsections (b) (2) and (c) filed 1-9-86; designated effective 2-2-86 pursuant to Government Code Section 11346.2 (d) (Register 86, No. 2).
2. Amendment of section and repealer and new NOTE filed 8-26-96 as an emergency; operative 9-3-96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1-2-97 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 97, No. 7).
4. Certificate of Compliance as to 8-26-96 order, including amendment of subsections (d) and (g), new subsection (h), and amendment of NOTE, transmitted to OAL 12-27-96 and filed 2-11-97 (Register 97, No. 7).

§ 2204. Billing and Payment of Fees.

(a) Fees for documents described in subdivisions (1) through (11) of § 2202(a) shall be computed and entered by the Commissioner on the Document Submission Formset accompanying the submission. One copy of the Document Submission Formset shall be returned to the submitter, who shall return it with its remittance of fees. See § 2216 for instructions on preparing the Document Submission Formset.

(b) Fees for all other documents described in this Article shall be entered on a Filing Fee Invoice supplied and prepared by the Commissioner.

(c) All filing fees shall be due and payable upon receipt of the completed Document Submission Formset or Filing Fee Invoice from the Commissioner.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506, 10704 and 12973.9, Insurance Code. Reference: Sections 742.42, 779.8, 1320, 10112.5, 10195.1, 10195.45, 10195.65, 10205, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 10717, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of subsection (c) filed 1–9–86; designated effective 2–2–86 pursuant to Government Code Section 11346.2(d) (Register 86, No. 2).
2. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2205. Cover Letter.

All document submissions must be accompanied by a cover letter in duplicate. The cover letter shall contain the following information.

(a) The form number(s) of one or more of the documents submitted by which the entire submission can be identified.

(b) The subdivision of Section 2202(a) which best describes the forms submitted and whether the forms are group, individual or are to be used in both contexts.

(c) Where the forms submitted provide hospital, medical or surgical coverage through employment, the minimum and the maximum sizes of the employers in terms of number of employees.

(d) Whether each document replaces a previously filed or approved document.

(e) Whether each document is in draft or printer's proof, or is in the final printed form in which it will be distributed to insureds.

(f) For each document (such as a rider) which is designed to be used with another document (such as a policy) not included in the submission, a statement of the type of documents with which it is to be used.

(g) Where a certificate is submitted for use with a previously approved "group" document, the form number and the filing or approval date of the previously approved group document.

(h) Should the submitter be unable to furnish the information requested in subdivisions (a) through (g) of this section, then the cover letter shall contain an explanation of why such information cannot be supplied.

(i) The cover letter shall be accompanied by a stamped, self–addressed business–size return envelope.

(j) Submitters wishing to receive acknowledgement of the Policy Approval Bureau's receipt of their submissions must include a self–addressed, postage pre–paid postcard or letter which the Bureau will return when it receives the submission. Acknowledgments must be drafted so that Department personnel need only enter dates of receipt before mailing; the Department will not telephone acknowledgements nor return acknowledgements by facsimile.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Repealer of former section 2205 and renumbering of former section 2206 to section 2205, including amendment of section and repealer and new NOTE, filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2206. Mailing Address.

(a) Submissions of documents described in subdivisions (1) through (11) of Section 2202(a), except for subdivision (4)(C), shall be addressed to:

CALIFORNIA DEPARTMENT OF INSURANCE
POLICY APPROVAL BUREAU
45 FREMONT STREET
SAN FRANCISCO CA 94105

(b) Submissions of documents described in subdivisions (4)(C), (12) and (13) of Section 2202(a) shall be addressed to:

CALIFORNIA DEPARTMENT OF INSURANCE
OFFICE OF THE CHIEF ACTUARY
300 SOUTH SPRING STREET
LOS ANGELES CA 90013

(c) Submissions of documents described in subdivisions (14) through (16) of Section 2202(a) shall be addressed to:

CALIFORNIA DEPARTMENT OF INSURANCE
CORPORATE AFFAIRS BUREAU
45 FREMONT STREET
SAN FRANCISCO CA 94105

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 1320, 10112.5, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 10717, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2206 to section 2205 and new section 2206 filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2207. Number of Copies Required.

Only one copy of each document need be submitted except as otherwise provided in Section 2214; documents described in Section 2202(a)(12) shall be filed in duplicate. Only those documents in the final printed form in which they will be issued will be formally approved or accepted for filing by the Commissioner.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 1320, 10112.5, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 10717, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2208. Group Certificates.

Each group policy submitted, except "wrap around" policies, must include the certificate or certificates to be issued therewith.

NOTE: Authority cited: Sections 742.43, 779.21, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.45, 10205, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10290, 10506, 10705 and 11658, Insurance Code.

HISTORY

1. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2209. Applications.

Applications and enrollment forms which are to be incorporated in documents which must be submitted to the Commissioner shall be subject to the same filing requirements as the documents in which they are to be incorporated, except as otherwise provided. Where a previously approved application is to be incorporated in a newly submitted document, the cover letter shall state the form number of such application and the date of the Commissioner's action upon it.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2210. Insert Sheets and Text Cells.

Submissions of additional or revised insert sheets for use with previously approved or filed documents must describe the types of documents with which they are to be used and the dates of such documents filing or approval by the Commissioner. Submissions of text cells must describe the types of documents in which they are to be used.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of section heading and section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2211. Form Numbers Required.

Every document submitted pursuant to this Article, except rate schedules, must have a form number which must not be identical with that on

any document previously filed or approved by the Commissioner for that insurer. A reprint of a previously approved form which contains any change whatsoever (subject to Section 2202(d), of this Article) is not the same form and its issuance is unlawful unless the reprint is properly submitted and filed or approved. If such changes are editorial in nature, the former form number with an identifying edition number, date or other suffix added will be accepted.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2212. Blanks to Be Completed.

All blanks in documents which are not obviously self explanatory shall be filled in with sample material which will indicate the use to be made of the blanks.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2213. Variable Text.

Submissions of documents containing variable text or blanks shall include complete lists of the variable wording or accurate descriptions of the material to be inserted in lieu of the variable wording or in the blanks of such documents.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Renumbering of former section 2213 to section 2214 and new section 2213 filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2214. Rate Schedules.

(a) Where the rates to be used with a submitted document are required to be filed or approved, they shall be included with the initial submission of the document.

(b) Cover letters for submissions of revisions of previously filed or approved rate schedules shall specify:

(1) The nature of the revision relative to the previously filed or approved rate schedules, including whether it will result in increases in premiums charged to existing insureds;

(2) The date of filing or approval of the rate schedule being revised; and,

(3) The form numbers and approval dates of the forms with which the revised rates are to be used.

(4) The Commissioner reserves the right to request additional information concerning revised rate schedules.

(c) Submissions of increases in previously filed or approved rate schedules which will result in increases in premiums charged to existing insureds shall be made in duplicate. Such submissions shall include copies of the revised rate schedules, but in the alternative, submitters may submit schedules displaying the revised rates to be charged to each California resident affected. Insurers desiring that rate filing supporting material be kept confidential in the Department's files must physically segregate that material from the rate schedules.

(d) Actuarially equivalent or deviated credit life and/or disability rates shall be submitted pursuant to any then–current rules of the Commissioner pertaining thereto. In the absence of such rules, submissions of such rates need not specify the form numbers of the documents with which they are to be used, but shall specify the type and amount of the deviation, the class of business, the type of coverage and the name of the creditor or creditors to which the deviated or equivalent rates will apply. Initial filings of upward deviated rates shall include copies of the policy or certificate forms to which those rates will apply.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10270.93, 10290 and 10717, Insurance Code.

HISTORY

1. Renumbering of former section 2214 to section 2215 and renumbering of former section 2213 to section 2214, including amendment of section and repealer and new NOTE, filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2215. Classifications of Risks.

Classifications of risks which must be filed with the Commissioner may either be included with a document with which they are to be used or may be submitted separately. Once a classification of risks has been filed, it may be used with any appropriate documents filed or approved before or after its date of filing by the Commissioner.

NOTE: Authority cited: Sections 10195.1, 10234, 10327 and 10704, Insurance Code. Reference: Sections 1320, 10112.5, 10270.93, 10290 and 10717, Insurance Code.

HISTORY

1. Incorporation of former section 2215 into section 2216 and renumbering of former section 2214 to section 2215, including repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2216. Document Submission Formsets.

(a) Submissions of all documents described in subdivisions (1) through (11) of Section 2202(a) shall include three–part Document Submission Formsets. Submitters shall provide their own supply of these formsets and shall complete them according to the instructions on the Specimen Document Submission Formset distributed with Department of Insurance Bulletin 94–6, dated July 5, 1994, available from the Department. The "Submitter and Complete Mailing Address" must be kept within the heavily–bordered box to match the Department's window envelopes. The "Submitter" is the person who should receive notice of Department action on the filing.

Document Submission Formsets shall be printe vertically on 8 1/2 inch by 11 inch paper following the exact format and content of the Specimen Document Submission Formset. Formsets must be printed on "No Carbon Required" paper or be interleaved with carbon paper, so that Department entries will print through to all copies. Formsets assembled from photocopies of the first sheet, without carbon paper interleaved, are unacceptable.

The Commissioner may note disapprovals or nonacceptances for filing on a copy of the Document Submission Formset returned to the submitter or by letter. Where a document has been rejected by notation on a Document Submission Formset, a new, properly–completed Document Submission Formset must be included if the document is resubmitted. Upon Approval or Acknowledgement for Filing, the Commissioner shall return one copy of the Document Submission Formset to the submitter. The Commissioner shall indicate his action on each document submitted in the appropriate column adjacent to the form number of the document in accordance with Section 2217.

(b) Documents described in different subdivisions of Section 2202(a) of this Article shall not be submitted with the same Document Submission Formset. Forms intended for use in both group and individual products shall be submitted only as individual forms, except where the individual form is not subject to filing; forms intended for use in both life and disability products shall be submitted only as disability forms.

(c) Document Submission Formsets accompanying rate filings shall display the form numbers of the documents to which the rates apply in the "Document Form Number" column and "Rates" in the "Doc Type" column.

(d) The Commissioner reserves the right to require Document Submission Formsets with submissions of any other documents which must be submitted for action. Such requirement may be imposed by prior notice to affected submitters by Bulletin, Notice or letter.

(e) The copy of the Document Submission Formset returned to the submitter by the Commissioner is the submitter's only evidence of the Commissioner's action on filings subject to this Section. Any conditions to the Commissioner's action may be noted either on the Formset or in a letter referred to on the Formset.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Renumbering of former section 2216 to section 2216(e) and renumbering of former section 2215 to section 2216(a)–(d), including amendment of section heading and section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2217. Definitions of Actions on Submissions.

(a) "Issue Authorized" (abbreviated as "AUT" on Document Submission Formsets) indicates that a document subject to prior approval maybe lawfully issued after the date of authorization.

(b) "Acknowledged for Filing" (abbreviated as "ACK") indicates that a document which must be filed with but not approved by the Commissioner may be issued or used after the date upon which it is Acknowledged for Filing.

(c) "Disapproved" (abbreviated as "DIS") indicates that a document subject to prior approval is defective and that its issue or use is unlawful.

(d) "Unacceptable for Filing" (abbreviated as "UFF") indicates that a document which must be filed with but not approved by the Commissioner is technically defective and its issue or use may be contrary to law.

(e) "Unobjectionable as to Text" (abbreviated as "UAT") indicates that a document subject to prior approval is free from substantive defect but its use or issue is unlawful either because it is not in final form or because another document with which it is to be used has not been Issue Authorized or Acknowledged for Filing.

(f) "Pending" (abbreviated as "PEN") indicates that a submission is incomplete and additional information or material is required before the Commissioner can take further action.

(g) "No Action" (abbreviated as "NAC") indicates that the document submitted is not required to be either filed with or approved by the Commissioner.

(h) "Withdrawn" (abbreviated as "WIT") indicates that the submitter has withdrawn a document from further processing by the Commissioner. Submissions which the Commissioner has "Disapproved" or deemed to be "Unacceptable for Filing", "Unobjectionable as to Text" or "Pending", and which have not been resubmitted for further processing within six months of such action, shall be deemed to have been withdrawn by the submitter.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 10112.5, 10195.1, 10195.45, 10205, 10225, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 11066, 11069 and 11658, Insurance Code.

HISTORY

1. Amendment of subsections (a)–(g), new subsection (h) and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2218. Workers' Compensation Forms and Rates.

(a) All workers' compensation insurance forms must be submitted in duplicate to the Workers' Compensation Insurance Rating Bureau of California for preliminary inspection. The Bureau shall review such forms and submit them to the Commissioner for final action.

(b) Workers' compensation rates shall be filed as provided in § 2509.30, et seq, of this Chapter.

NOTE: Authority cited: Sections 11658 and 11659 Insurance Code. Reference: Sections 11658, 11659 and 11735, Insurance Code; and Section 2509.30, et seq, Code of Regulations, Title 10.

HISTORY

1. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).
2. Amendment filed 12–30–83; designated effective 1–1–84 pursuant to Government Code Section 11346.2 (d) (Register 84, No. 1).
3. Amendment of section heading and section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2218.1. Effective Date.

Sections 2200 through 2218 as amended in 1997 will govern all initial submissions and resubmissions of the documents described in Section 2202 of this Article received by the Commissioner on or after March 13, 1997.

NOTE: Authority cited: Sections 742.43, 779.21, 9080.1, 10163.3, 10195.1, 10234, 10327, 10489.93, 10506, 10704, 11027, 11029, 11066, 11069, 11521.5, 11658, 12250 and 12973.9, Insurance Code. Reference: Sections 742.42, 779.8, 795.5, 1320, 9080.1, 10112.5, 10163.3, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10489.93, 10506, 10705, 10717, 11027, 11029, 11066, 11069, 11522, 11658 and 12250, Insurance Code.

HISTORY

1. Amendment of section and repealer and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2218.2. Authority; Purpose; Application.

(a) This regulation is promulgated under the authority granted to the Commissioner in Section 10191 of the Insurance Code. Its purpose is to establish and maintain a procedure for the filing and approval of group and blanket life and disability documents written by admitted insurers or non–profit hospital service plans in California pursuant to the provisions of Section 10191, in lieu of the requirements for the submission, filing or approval of such documents otherwise set forth in the Insurance Code.

(b) This regulation is applicable to all insurers and non–profit hospital service plans authorized to transact life or disability business in California and to all group and blanket life and disability documents to be issued or delivered in California, excepting certificates and other documents used under policies validly authorized and issued in other jurisdictions and other documents specifically excepted herein or by statute. All documents subject to this regulation will be filed in accord with this regulation after its effective date.

NOTE: Authority cited for Sections 2218.2 through 2218.10; Section 10191, Insurance Code.

HISTORY

1. New Sections 2218.2 through 2218.10 filed 4–27–70; designated effective 7–1–70 (Register 70, No. 18).

§ 2218.3. Prior Inconsistent Regulation Superseded.

NOTE: Authority cited: Sections 742.43, 779.21, 10195.1, 10234, 10327, 10506 and 10704, Insurance Code. Reference: Sections 742.42, 779.8, 1320, 10112.5, 10195.1, 10195.45, 10195.65, 10205, 10225, 10231.6, 10232, 10270, 10270.1, 10270.2, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9, 10270.93, 10290, 10292, 10436, 10506, 10705, 10717, 11066 and 11069, Insurance Code.

HISTORY

1. Repealer filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2218.4. Insurer's Responsibility to Comply.

Approval under Section 10191 is in lieu of prior substantive review and does not constitute prior text approval except to the extent that certain language may be described or defined in any document guidelines adopted by the Department. It is the responsibility of the insurer to effect compliance with all applicable statutory provisions, regulations, and any guidelines adopted by the Department.

§ 2218.5. Filing Procedure; Approvals; Disapprovals.

(a) All submissions are to include:

(1) A cover letter complying with § 2205.

(2) A Document Submission Formset complying with § 2216 and one copy of all relevant Certificates of Compliance set forth in Section 2218.9 below. When a submission does not contain a policy, one or more documents may be submitted under one Certificate of Compliance and the Document Submission Formset shall indicate the policy forms or category of forms with which each document will be used, and the Certificate shall be marked to indicate which affirmations are relevant to which document. When a submission contains a policy, only that policy and its related forms may be included.

(3) One copy of the submitted forms if the documents do not vary from applicable statutes or regulations, or two copies if there are any substan-

tive variations. All such variations are to be clearly marked or indicated on both copies and where not inconsistent with this regulation shall be filed in conformity with Sections 2200 – 2217.

(b)(1) Except as provided in Section 2218.10, group and blanket life and group disability forms shall be approved for use without review when accompanied by a Certificate or Certificates of Compliance which conform with the requirements of this regulation. The date of approval for use will be the date stamped by the Insurance Department on the copy of the Document Submission Formset returned to the insurer. When such forms are approved for use under Section 10191, one copy of the Document Submission Formset will be returned to the insurer with that fact and the filing charges and invoice number indicated thereon.

(2) If such forms are not approved for use, that fact will be indicated on the copy of the Document Submission formset and the objections to approval will be noted either by letter or on one copy of the Document Submission Formset or on the second copy of such forms and returned to the insurer, and the Department shall specify the reasons the submitted forms do not comply with the particular sections of the statutory provisions or regulations or guidelines.

NOTE: Authority cited: Sections 10191 and 10327, Insurance Code. Reference: Sections 1320, 10112.5, 10205, 10225, 10270, 10270.1, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9 and 10290, Insurance Code.

HISTORY

1. Amendment of section and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

§ 2218.6. Subsequent Review of Approved Forms.

Documents which are returned to the insurer by the Department as approved and filed for use under Section 10191, as provided in Section 2218.5 (b) (l) of this regulation, may be subsequently reviewed by the Insurance Commissioner when he deems necessary. The review by the Commissioner shall be based upon the guidelines in effect on the date the document was filed.

§ 2218.7. Guidelines; Adoption by Commissioner.

To facilitate compliance with this regulation, the Commissioner will adopt which the initial guidelines were developed appropriate guidelines. The guidelines will be periodically brought to date by appropriate revisions, and such revisions will be developed in the same manner in which the initial guidelines were developed.

§ 2218.8. Submission Forms.

All documents submitted under this regulation shall be accompanied by a Document Submission form and the appropriate Certificate or Certificates of Compliance. In the event a document applies to both group life and group disability, it shall be accompanied by a Group Life Certificate of Compliance and a Group Disability Certificate of Compliance. Such Certificates shall use 8–point or larger type sizes.

§ 2218.9. Document Submission Forms and Certificates of Compliance.

Specimen copies of the following forms are available from the Legal Division of the Department of Insurance. Submitters are responsible for obtaining their own supplies of such forms.

Document Submission Formset
Group Life Certificate of Compliance
Group Disability Certificate of Compliance
Blanket life Certificate of Compliance
Blanket Disability Certificate of Compliance
Tuition Refund Certificate of Compliance

NOTE: Authority cited: Sections 779.21, 10191, 10506 and 10507.4, Insurance Code. Reference: Sections 779.8, 779.13, 10205, 10205.5, 10205.6, 10225, 10270.1, 10270.2, 10270.3, 10270.5, 10270.57, 10270.9, 10270.91, 10270.92, 10270.93, 10290, 10292, 10506, 10507.2, 11066, 11069, 11512.4, 11513, 11513.1, 11513.2, 11515 and 11658, Insurance Code.

HISTORY

1. Repealer and new section filed 1–9–86; designated effective 2–2–86 pursuant to Government Code Section 11346.2(d) (Register 86, No. 2).

§ 2218.10. Forms Requiring Prior Substantive Review.

(a) This regulation shall control the filing of all group and blanket life and group disability insurance documents required by law to be filed by the Sections cited in Ins. C. §10191 except the following which must submitted for prior substantive review in accord with contemporary Department standards:

(1) Document filings involving concepts of insurance or types of coverage which may be considered as uncommon or unusual and which are not encompassed in any form of the insurer authorized by this Department at the time of the said filing, nor in any form filed in this State from which the submitted form has been copied.

(2) Documents proposed for use in transacting either group life, group disability, blanket life insurance in California, where the submitting insurer has not been:

(A) admitted to transact the relevant classes of business in California, and

(B) actively transacting the type of insurance in question in California for three years prior to the date of the submission, unless and until such prior substantive review is expressly waived by the Commissioner in writing.

(b) The Commissioner may for reasonable cause and upon written notice to the insurer reinstate a prior substantive approval requirement as to an insurer for whatever length of time he has reasonable cause to require such prior substantive approval in the interest of the public.

NOTE: Authority cited: Sections 10191 and 10327, Insurance Code. Reference: Sections 1320, 10112.5, 10205, 10225, 10270, 10270.1, 10270.3, 10270.5, 10270.507, 10270.57, 10270.9 and 10290, Insurance Code.

HISTORY

1. Amendment of section and new NOTE filed 2–11–97; operative 3–13–97 (Register 97, No. 7).

Article 1.1. Insurer Notice and Consent Forms; Confidentiality Requirements

§ 2218.20. Informed Consent for Testing Genetic Characteristics and Confidentiality Agreement.

(a) To obtain the informed consent to test genetic characteristics of an applicant for life or disability income insurance, or of the proposed insured if the applicant and proposed insured are not one person, and to assure confidentiality of tests of genetic characteristics, life and disability income insurers must use a document, printed in at least 10–point typeface, containing the languages set forth below (but not the instructions indicated in brackets and bold type–face). Blanks must be filled in, as indicated in the bracketed instructions, prior to delivery of the form to an applicant, or proposed insured (as appropriate), for review and signature. A life or disability income insurer that obtains an informed consent and confidentiality agreement with respect to a test of genetic characteristics must give a copy of the signed agreement to the insured.

NOTICE AND CONSENT TO TEST GENETIC CHARACTERISTICS AND CONFIDENTIALITY AGREEMENT

To determine whether or not to issue a life and/or a disability income insurance policy to you, and for purposes specified below, if any, which are related to a determination whether or not to issue a life and/or a disability income policy to you, we, **[Insert full name of insurer.]**, require you to undergo testing of your genetic characteristics. Accordingly, we request your authorization to test you for the following scientifically or medically identifiable gene(s) or chromosome(s), or alteration(s) thereof, which is/are known to be a cause of, or which is/are determined to be associated with a statistically increased risk of development of the following disease(s) or disorder(s):

Gene/Chromosome: **[Indicate gene(s) or chromosome(s).]**
Disease/Disorder: **[Indicate disease(s) or disorder(s).]**

We will not obtain a test of any other genetic characteristics unless, in accordance with applicable law, we obtain an additional, separate written consent from you to do so. We will only test genes or chromosomes, or alterations thereof, which are presently associated with symptoms of the disease(s) or disorder(s) indicated above. We will, however, test the gene(s) or chromosome(s), or alteration(s) thereof, indicated above, which are presently associated with symptoms of the disease(s) or disorder(s) indicated above, whether or not you presently have symptoms of the disease(s) or disorder(s) with respect to which the test(s) will be conducted. We will pay the full cost for administering the test(s) of the gene(s) and/or chromosome(s) indicated above, interpreting the results of the test(s) specified above to the extent we consider necessary to make our determination whether or not to issue a life and/or disability income policy to you, and informing you about the results and interpretation of the test(s).

The following test(s) will be performed on you: **[Identify each test by name and scientific reference identifier, if any.]**

[Here, indicate what will be tested, and by whom, and, in plain language, the test methodology. For example, "The X laboratory will take a sample of your blood and examine it microscopically." Also provide the address and telephone number of the tester.]

Our primary purpose of the test(s) authorized by you is to obtain information about: **[State the genetic characteristic(s) which will be indicated by the test or tests listed above.]**, in order to determine whether or not to issue a life and/or disability income insurance policy to you.

Other uses of the test(s) authorized, which are related to making a determination whether or not to issue a life and/or disability income insurance policy to you, include: **[Indicate all uses which you will make of the test results, including but not limited to a decision about underwriting, and the effect of the results of the test(s) on premiums.]** We will not use the tests for any other purposes.

Limitations of the test(s) include: **[For each test authorized, indicate the limitations of the test, including, but not limited to, the relative degree of accuracy of each.]**

We will notify you promptly and in writing about the results of the test(s) of your genetic characteristics. Our written notice to you of those results will provide you with the interpretation of the results of the test(s) of your genetic characteristics which we obtain with respect to making a determination whether or not to issue a life and/or disability income insurance policy to you. We recommend that you give us the name and address in the space below of a physician who can explain the test results and the interpretation of those results which we obtain more fully to you. If you give us the name and address of such a person, we will send the test results and the interpretation of those results which we obtain to that person and notify you in writing that we have done so. If you do not give us the name of a physician, we will send the test results and the interpretation of those results which we obtain directly to you.

We will treat the fact that you were asked to be tested, and whether or not you agreed to be tested, and the results and interpretation of the results of your test(s) which we obtain confidentially. Only persons within our company or under contract with our company who have a need to know about the testing and the test results for our underwriting purposes, and persons necessarily involved in administering the test and interpreting the test results for us, will have access to information about our request to test your genetic characteristics, whether or not you agreed to be tested for genetic characteristics for us, or the results and interpretation of the results of the test(s) of your genetic characteristics which we obtain. We will not disclose, nor allow anyone under contract with us or in our employ to disclose, information about our request to test your genetic characteristics, whether or not you agreed to be tested for genetic characteristics for us, or the results and interpretation of the results of the test(s) of your genetic characteristics which we obtain to anyone else unless you first authorize us in writing to do so, or we are compelled by law to do so.

Your signature below indicates that you have read and you understand this Notice and Consent to Test Genetic Characteristics and Confidentiality Agreement, and the obligations imposed on us by this document, and you voluntarily agree to submit to the test(s) indicated above. Your signature also indicates that you have received a copy of this document, and that a photocopy of this document which reflects your signature may be used by us to obtain testing of your genetic characteristics, as indicated above.

This authorization to test your genetic characteristics expires ninety (90) days from the date you sign it; however, you may revoke it at any time. Our obligations set forth in this Notice and Consent to Test Genetic Characteristics and Confidentiality Agreement, including but not limited to our obligations regarding confidentiality, do not expire, nor may we revoke or amend them without your prior written consent.

_____ _____

Signature of Proposed Insured Date

_____

Signature of Parent or Guardian
(When required by law)

Physician to Whom Test Results May Be Sent:
Name: _____ Address: _____ Telephone: _____

NOTE: Authority cited: Article 2.6 of Chapter 1 of Part 2 of Division 2 and Section 10148, California Insurance Code. Reference: Article 2.6 of Chapter 1 of Part 2 of Division 2 and Sections 10146–10149.1, California Insurance Code.

HISTORY

1. New article 1.1 (section 2218.20) and section filed 3–5–98; operative 4–4–98 (Register 98, No. 10).

Article 1.3. Mandated Benefits Analysis Regulations

§ 2218.60. Definitions.

(a) The term "health insurer" means any disability insurer that issues a policy of "health insurance" as defined in California Insurance Code Section 106.

(b) The term "number of covered lives" means the sum of all named insureds and all covered dependents insured by a health insurer.

(c) The term "percent to total ratio" means the total number of covered lives insured by a health insurer in the state of California divided by the total number of covered lives insured by all health insurers in the state of California.

(d) The term "total need" means the dollar amount the Department of Insurance has determined that it is responsible for and has stipulated in order to fund the University of California study of mandated benefits required by California Health and Safety Code Section 127760. The dollar amount of the "total need" shall be calculated in the manner described in 2218.61(b).

NOTE: Authority cited: Sections 127662 and 127664, Health and Safety Code; and Sections 12921 and 12926, Insurance Code. Reference: Section 106, Insurance Code; and Sections 127660, 127661, 127662, 127663 and 127664, Health and Safety Code.

HISTORY

1. New article 1.3 (sections 2218.60–2218.63) and section filed 4–1–2005; operative 5–1–2005 (Register 2005, No. 13).

§ 2218.61. Assessment of Fee.

(a) Each health insurer shall be assessed, and shall pay, a fee in an amount determined by the formula set forth in Section 2218.62 for each policy written in California for insurance or group disability insurance that provides coverage for hospital, medical, or surgical benefits; however, health insurance described in Health & Safety Code Section 127662(c)(4) shall not be subject to any assessment by the Commissioner.

(b) The dollar amount of total need shall be determined by the Department of Insurance and the Department of Managed Care in consultation with the University of California and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its

work in implementing Health and Safety Code Section 127660. The total amount of assessment on health insurers and health care service plans when combined together shall not exceed two million dollars ($2,000,000.00) annually. The total annual assessment of health insurers shall not exceed 12.4% of the total annual assessment of health insurers and health care services plans combined.

(c) The Commissioner shall calculate and levy an assessment of all health insurers equal to the appropriation contained in the State Budget for the administrative and operational costs arising from the provisions of Chapter 7 (commencing with Section 127660), Part 2 of Division 107 of the Health and Safety Code plus or minus such amounts as the Commissioner deems necessary as a contingency against unanticipated fluctuations in expenditures and revenues and plus or minus such amounts as the Commissioner deems necessary to correct for over–collections or under–collections in prior years.

(d) The Commissioner may adjust the amount set forth in (b) above as necessary to minimize costs by excluding assessment amounts that are too small to justify the cost of such assessment and collection or if such assessment or collection is impractical.

NOTE: Authority cited: Sections 127662 and 127664, Health and Safety Code; and Sections 12921 and 12926, Insurance Code. Reference: Section 106, Insurance Code; and Sections 127660, 127661, 127662, 127663 and 127664, Health and Safety Code.

HISTORY

1. New section filed 4–1–2005; operative 5–1–2005 (Register 2005, No. 13).

§ 2218.62. Formula for Calculating Fee.

(a) The formula for calculating the fee assessed from each health insurer set forth pursuant to 2218.61 shall be based on the number of covered lives insured by a health insurer in the calendar year preceding the first day of the fiscal year in which the assessment is made, calculated by annual statement line of insurance.

(b) The formula for calculating the fee as described in Section 2218.61 is as follows: The aggregate of all covered lives insured by an insurer will be used to determine a percent–to–total ratio for each insurer. This ratio will be multiplied by the total need as defined in Section 2218.60(d) to calculate the amount of the fee to be assessed to each insurer.

NOTE: Authority cited: Sections 127662 and 127664, Health and Safety Code; and Sections 12921 and 12926, Insurance Code. Reference: Section 106, Insurance Code; and Sections 127660, 127661, 127662, 127663 and 127664, Health and Safety Code.

HISTORY

1. New section filed 4–1–2005; operative 5–1–2005 (Register 2005, No. 13).

§ 2218.63. Issuance of Invoice and Disposition of Assessment Proceeds.

(a) The Department of Insurance shall issue an invoice to each health insurer setting forth the amount of the assessment owed. The invoice shall be issued no later than the fifteenth day of June for any assessment.

(b) The invoice described in Section 2218.63(a) shall assess a fee calculated in the manner described in 2218.62 from each health insurer for the Fiscal Years 2006–07, 2007–08, 2008–09 and 2009–10.

(c) Any amount set forth in the invoice described in 2218.63(a) shall be due and payable upon receipt and shall be considered delinquent if the total amount invoiced is not received within 45 days of the date that the invoice is issued.

(d) Fees assessed and collected pursuant to this section shall be deposited in the Health Care Benefits Fund for the sole purpose of collecting and disbursing funds for the administrative and operational costs arising from the provisions of Chapter 7 (commencing with Section 127660), Part 2 of Division 107 of the Health and Safety Code.

NOTE: Authority cited: Sections 127662 and 127664, Health and Safety Code; and Sections 12921 and 12926, Insurance Code. Reference: Section 106, Insurance Code; and Sections 127660, 127661, 127662, 127663 and 127664, Health and Safety Code.

HISTORY

1. New section filed 4–1–2005; operative 5–1–2005 (Register 2005, No. 13).
2. Amendment of subsection (b) filed 10–10–2007; operative 11–9–2007 (Register 2007, No. 41).

Article 1.5. Standards for Determining Conformity of Individual Disability Policies with the Provisions of Paragraph (7) of Subdivision (b) of Section 10291.5 of the Insurance Code

§ 2219. Purpose and Scope.

Insurance Code Section 10290 requires all individual disability policy forms must be submitted to the Insurance Commissioner for approval. The provisions of this Article, as specified, are applicable to all such disability policy forms submitted to the Insurance Commissioner for approval on and after January 1, 1973. Subdivision (c) of Section 10291.6, Insurance Code, provides that the Insurance Commissioner may promulgate rules establishing certain standards, conforming to the provisions of Subdivision (b) of said Section 10291.5, by which individual disability policies will be disapproved or approval thereof withdrawn, other than as provided in Subdivision (j) of Insurance Code Section 10291.5. This Article contains some standards of that nature, but such standards herein are limited to standards conforming to the provisions of Paragraph (7) of said Subdivision (b) by which such policies will be disapproved or approval thereof withdrawn. Such standards cannot anticipate all insurance benefits which may be contained in policies hereafter submitted for approval. Promulgation of these rules does not limit the responsibility of the Commissioner, imposed upon him by law, in respect to all such policy forms, to approve, disapprove or withdraw approval of policy forms in accordance with all applicable statutes and regulations.

HISTORY

1. New Article 1.5 (2219, 2220, 2220.1 to 2220.26, inclusive) filed 10–25–50; effective thirtieth day thereafter (Register 22, No. 2).
2. Repealer of Article 1.5 and new Article 1.5 (2219, 2220, 2220.1 through 2220.31 filed 11–3–72; effective thirtieth day thereafter (Register 72, No. 45).

DEFINITIONS

§ 2220. Terms Defined.

As used in this article the words and phrases defined in Sections 2220.1 to 2220.6 have the meanings set forth therein.

§ 2220.1. Policy.

(a) "Disability policy" or "policy" or "policy form" includes all of the following except when issued to: (1) supplement Medicare (Health Insurance for the Aged Act, Social Security Amendments of 1965, as amended) other than to the extent specified in this Article; or (2) to supplement other governmental programs; or (3) when issued as credit disability insurance written in accordance with the provisions of Article 5.9, Division 1, Part 2 of the Insurance Code; or (4) when issued as mortgage disability insurance; or (5) when issued as a conversion policy when group coverage (either insured or noninsured) is terminated, or when issued in accordance with a conversion privilege specified in any in–force individual policy:

(1) A policy of disability insurance insuring only one person;

(2) A policy of family disability insurance as defines in either Insurance Code Section 10270.7 or 10320(c);

(3) A policy of disability insurance issued on a selected group basis pursuant to Insurance Code Section 10270.97; and

(4) Any rider or other document or endorsement attached or to be attached, as a part thereof, to any policy described in (1), (2) or (3) above.

(b) A rider issued to be attached to an in–force policy is not subject to the provisions of Sections 2220.8 to 2220.30, inclusive, if the rider modifies a benefit of the same type contained in the policy by increasing its amount, extending the duration of payment, reducing the waiting period, reducing the elimination period, reducing a deductible or reducing a coinsurance percentage factor.

§ 2220.2. Industrial Insurance.

"Industrial Insurance" means that form of disability insurance embodied in a disability policy which is issued on an industrial debit basis and

which provides, at issue, either: (a) that premiums are payable weekly, or (b) that premiums are payable monthly at a rate not greater than $15.00 per person insured per month.

It shall be presumed for the purposes of this Article that a policy will not be issued on an industrial debit basis unless:

(1) The words "Industrial Policy" are printed upon the policy as a part of the descriptive matter, or

(2) When submitted to the Commissioner, it is accompanied by a written certificate, over the signature of an executive officer of the company, to the effect that such policy will be issued on such basis only.

§ 2220.3. Waiting Period.

"Waiting period" means the period of time specified in a policy which must follow the issue, or reinstatement, date of the policy in respect to a particular insured person before the coverage or coverages of the policy become effective as to such insured person.

§ 2220.4. Elimination Period.

"Elimination period" means the initial period of time, during the continuance of a continuance insured against and specified in respect to a particular benefit, for which such benefit will not be paid.

§ 2220.5. Dismemberments.

"Double dismemberment" means dismemberment described and defined in Insurance Code Section 10291.5 (b) (8) (i); and "single dismemberment" means loss of one only of any of the members described in such Code Section.

§ 2220.6. Time and Amount Equivalents.

Periods of time or dollar amounts defining standards in this Article may also be expressed in rounded equivalents. For example, the following, respectively illustrate equivalent periods of time:

(1) One month, four weeks and thirty days.

(2) Three months, thirteen weeks and ninety days.

(3) Twelve months, one year and three hundred sixty days.The following, respectively, illustrate equivalent dollar amounts:

(1) "$100 per month" and "$25 per week."

(2) "$300 (or $280) per month" and "$70 per week" and "$10 per day."

A benefit payable as long as the insured shall live and remain disabled shall be deemed to be payable for a period of time not less than any period of time specified in the standards contained in this Article.

STANDARDS

§ 2220.7. Effect of Standards.

Any policy containing a type of coverage which, under the provisions of Sections 2220.8 to 2220.30, inclusive, shall be deemed not sufficient to be of real economic value to insureds shall be disapproved by the Commissioner unless it is specifically demonstrated to him in writing to his satisfaction that such coverage will be of real economic value to insureds under the special circumstances of issuance, in which case the Commissioner shall approve issuance of such policies only in such special circumstances. This section shall be liberally construed to permit experimentation and adaptation to economic or social changes, which the Commissioner hereby declares to be in the public interest.

§ 2220.8. Exceptions, Limitations and Reductions.

(a) A benefit shall be deemed not sufficient to be of real economic value to the insured if it is subject to exceptions, limitations or reductions concerning any subject matter other than the following:

(b) War; service in armed forces; workers' compensation; participation in a riot or insurrection; suicide or attempted suicide; intentionally self-inflicted injury; voluntary or involuntary inhalation of gas; mental or emotional disorders or functional nervous disorders; pregnancy or childbirth; treatment on or to the teeth or gums except when necessitated by accident; hallucinatory drugs; while a passenger other than a fare-paying passenger in any aircraft or while passenger in a military aircraft or acting as pilot or crew in any aircraft; facilities for treatment of armed forces members or ex-members except when an actual charge is made; services for which no charge is made in the absence of insurance; services covered under any governmental plan except those governmental plans which by law either define or specify disability insurance coverage as primary; rest cure or routine medical examinations; eye refractions or eye glasses; hearing aids; surgery for cosmetic purposes; motorcycle use; racing contests; professional athletics; hazardous avocations (when the hazardous avocation is specified specifically); reasonable territorial limits.

(c) A limitation which constitutes a reasonable definition of the losses covered and the benefits provided shall not be construed as materially lessening the value of the benefit if the definition is not otherwise inconsistent with any provision of this Article.

(d) The words "exceptions, limitations, or reductions" as used in this section shall not prohibit any provision which the Insurance Code specifies permissible or which is approved by the Insurance Commissioner, and shall not include any provision contained in any insuring paragraph or paragraphs that modifies solely the subject thereof, where such insuring paragraph or paragraphs, including such provision, constitutes, over all, an affirmative definition of one of the hazards, a class of hazards or all of the hazards which the policy insures against and which the Insurance Commissioner deems to be a reasonable definition or statement of one or more of the hazards which the policy insures against.

(e) This section shall not apply to any matter contained in any rider the original or copy of which is signed by the insured and issued for attachment to the policy when the policy is issued or reinstated when the rider is used solely to waiver coverage for existing specified medical or physical conditions which actually exist. Such a rider may also be used to waive coverage for specified hazardous avocations.

The words and phrases designated in this section as "subject matters" of exceptions, limitations and reductions are to be given a broad generic interpretation and do not control the actual words or phrases used are not less favorable to the insured person than the words or phrases used in this section.

History

1. Amendment of subsection (b) filed 12-2-75; designated effective 1-1-76 (Register 75, No.49).

§ 2220.9. Authority of Insurance Commissioner to Approve Other Exceptions, Limitations and Reductions.

The provisions of Section 2220.8 shall not be deemed to prohibit the Insurance Commissioner from approving the subject matter of other exceptions, limitations and reductions under the procedure specified in Section 2220.7 when the insurer demonstrates to the satisfaction of the Commissioner the need and the reasonable scope of the exception, limitation or reduction in writing to the Commissioner.

[The next page is 533.]

§ 2220.10. Waiting Periods.

A sickness benefit shall be deemed not sufficient to be of real economic value to a covered person if one or more coverages become effective more than 30 days after the effective date of the policy or rider or is subject to a waiting period greater than:

(a) Ten months for pregnancy, childbirth or miscarriage; or when the waiting period is expressed in terms of the inception of the pregnancy, 30 days after the effective date of the policy or rider; or

(b) Six months for hernia; disorder of the reproductive organs; tuberculosis; cancer; tumors; varicose veins; adenoids; appendix; tonsils; gallbladder; rectum; thyroid gland, and diseases of the heart; and

(c) Twelve months for organ transplant, cosmetic surgery or dental insurance.

§ 2220.11. Loss–of–Time Generally.

A loss–of–time benefit provided by a policy shall be deemed not sufficient to be of real economic value to the insured if:

(a) Its amount is less than:

(1) $100 per month payable at ages up to 62 and $50 per month payable at ages after 62; except

(2) In the case of industrial insurance or insurance issued to cover persons not gainfully employed, if its amount is less than $60 per month payable at ages up to 62 and $30 per month payable after age 62; or

(b) Its elimination period, if any, exceeds:

(1) 90 days in the case of a policy which provides a benefit period of one year or less; or

(2) 365 days if the benefit is payable for not less than two years and is payable in an amount less than $200 per month; or

(3) 180 days in all other cases.

(c) The maximum period of time for which it is payable during disability, other than as specified in Subsection (b) of this section, is less than:

Six months, except in the case of such a benefit payable for disability arising out of pregnancy, childbirth or miscarriage the benefit period may be one month.

Subsection (a) of this section shall not apply to additional loss–of–time benefits issued by the same insurer by rider or issued by the same insurer under guaranteed insurability or future purchase option provisions which are part of the policy or benefits issued by application of a cash dividend. The Commissioner may, in accordance with the provision of Section 2220.7, in his discretion, approve other loss–of–time benefits designed and actually programmed to supplement continuance programs, California Unemployment Compensation Disability benefits and Social Security total disability benefits.

The phrase "actually programmed" as used in this section and in Section 2220.15, means an insurance program designed for a specific person in a person to person face to face interview with the individual insured or prospective insured by an insurance agent or broker.

§ 2220.12. Partial Disability.

Section 2220.11 shall not be applicable to a loss–of–time benefit for partial disability which complies with Subsections (b) (2) and (3) of Insurance Code Section 10291.5, irrespective of the amount of the partial disability benefit or the length of time for which is payable, when contained in a policy providing loss–of–time coverage otherwise complying with Section 2220.11.

DISMEMBERMENT AND ACCIDENTAL DEATH BENEFITS

§ 2220.13. Accidental Death Amounts.

A benefit for accidental death shall be deemed not sufficient to be of real economic value to the insured if its amount is less than $1000.

§ 2220.14. Dismemberment Amounts.

A benefit for dismemberment regardless of whether resulting from accident or sickness [excluding any such benefit for which an amount is determined in accordance with the provisions of Insurance Code Section 10291.5 (b) (8)] shall be deemed not sufficient to be of real economic value to the insured if:

(a) When a double dismemberment, its amount is less than $1000; and

(b) When a single dismemberment, its amount is less than $500.

BASIC MEDICAL BENEFITS

§ 2220.15. Basic Hospital Benefits.

(a) A hospital benefit, other than a benefit described in Sections 2220.17 or 2226.20, shall be deemed not sufficient to be of real economic value to the insured if:

(1) The amount of the daily hospital benefit for each covered confined person (provided on either an expense incurred basis or on other than an expense incurred basis) is less than $30.00 per day provided, however, that a policy may provide benefits on an expense incurred basis up to that amount; or

(2) The period the benefit is payable is less than 60 days; or

(3) The amount of the daily hospital benefit for each covered confined person is less than $40.00 per day for the next 53 days; or

(4) The elimination period, if any more than three days for sickness benefits and three days for accident benefits.

(b) This section does not prohibit a policy or rider designed and actually programmed to provide hospital benefit for a specified individual to supplement existing in force coverage if (i) such supplemental daily hospital benefit is not less than $10.00 and the benefit period is not less than 60 days, or (ii) the benefit period is equal to the benefit period of existing in force coverage, or (iii) is a rider issued at the same time as the policy by the same insurer to provide full coverage benefits, such as, a rider to either eliminate or reduce a deductible, waiting period or elimination period.

(c) This section does not apply to additional daily hospital benefits issued to the insured by the same insurer under guaranteed insurability, future purchase options or other similar policy provisions such as, additional benefits issued by application of a cash dividend.

(d) This section does not prohibit a hospital benefit which, in the opinion of the Commissioner, is not less than the actuarial equivalent of one of the benefits specified in Subsection (a) of this section.

§ 2220.16. Basic Miscellaneous Hospital Services Benefits.

Except to the extent provided otherwise in Section 2220.20, a benefit covering miscellaneous hospital services (other than a benefit described in Sections 2220.19 and 2220.22) shall be deemed not sufficient to be of real economic value to the insured if.

(a) When the benefit specifies a blanket amount for miscellaneous hospital services for unnamed items, such blanket amount is less than five times the largest daily hospital benefit of the policy; or

(b) When the benefit specifies a blanket amount for miscellaneous hospital services for a number of named items, such blanket amount is less than five times the largest daily hospital benefit of the policy, or the items named are less than six in number; or

(c) When the benefit specifies a separate limiting amount per separate item named, the amount per item is less than $15.00 and the aggregate limiting amount for all such items is less than $150 or the items named are less than seven in number and the amounts are not reasonably related; or

(d) Less than six of such items if separately named are of a reasonably normal frequency or occurrence; and

(e) It does not provide benefits under either (a) or (b) or (c) above for diagnostic X–rays, laboratory tests and electrocardiograms on an in–patient basis and also on an out–patient basis for preadmission hospital testing when the procedures are performed within 72 hours of admission to the hospital.

A policy or rider which contains the benefits of this section and Section 2220.15 may be subject to a combined deductible not in excess of $100.00, except that if the miscellaneous hospital service benefits are not less than ten times the daily hospital benefit, the combined deductible may be not in excess of $150.00. This section shall not prohibit a miscellaneous hospital services benefit which, in the opinion of the Commis-

sioner is not less than the actuarial equivalent of one of the specified benefits in this section.

§ 2220.17. Basic Hospital Benefits Expressed as Increases of Loss–of–Time Benefits.

A benefit expressed as an increase of a loss–of–time benefit (Section 2220.11) during hospital confinement shall be deemed not sufficient to be of real economic value to the insured if:

(a) The increase in the loss–of–time benefit is less than either the lesser of the basic loss–of–time amount required under Section 2220.11 or, if expressed otherwise, if it is less than $300.00 per month, or if the benefit is payable for less than two months duration; except

(b) In the case of industrial insurance, if the increase in the loss–of–time benefit is less than either the lesser of the basic loss–of–time amount required under Section 2220.11 or, if expressed otherwise, it is less than $150 per month, or if the benefit is payable for less than one month duration.

§ 2220.18. Basic Private Duty Nurse Benefit.

A policy which provides a benefit for in hospital or out of hospital private duty nursing by either a licensed registered nurse (R.N.) or a licensed vocational nurse (L.V.N.) shall be deemed not sufficient to be of real economic value to an insured if:

(a) The amount of the daily private duty nursing benefit is less than $18.00 per shift for not less than one shift per day for a licensed registered nurse or $12.00 per shift for not less than one shift per day for a licensed vocational nurse; or

(b) The maximum period of time for which the benefit is payable is less than 10 days.

A policy which provides a nurse benefit for professional nurse home calls–by either a registered nurse or a vocational nurse shall be deemed not to be of real economic value to the insured unless the benefit equals not less than 25 percent of the benefit provided under Subsections (a) and (b) of this section and is not subject to elimination periods of more than the first three home calls for a sickness benefit and not more than the first three home calls for an accident benefit. A "home call" for the purpose of this section means a personal home visit during any one twenty–four hour period.

§ 2220.19. Basic Accident Emergency Treatment Benefit.

A separate basic accident emergency treatment benefit shall be deemed not sufficient to be of real economic value to the insured if:

(a) The amount of the benefit is less than one day of the loss–of–time benefit (without application of any elimination period) but in no event less than $10.00 when an emergency accident treatment benefit is provided on other than an expense incurred basis in a loss–of–time policy; or

(b) The benefit is payable on an expense incurred basis, and the amount is less than $25.00; or

(c) The benefit is payable, irrespective of the expense incurred, in other than a loss–of–time policy, and the amount payable is less than $10.00.

§ 2220.20. Basic Blanket Medical Expense Benefits.

A benefit providing basic blanket coverage (coverage without inside dollar limits for specific items) for basic medical expenses shall not be subject to the provisions of Sections 2220.15, 2220.16 and 2220.17 but shall be deemed not sufficient to be of real economic value to the insured if.

(a) When an accident benefit, its limit is less than $1,000 or the expenses for which it is payable are limited to those incurred within a period of less than six months following each separate accident; or

(b) When a sickness benefit, other than a benefit described in Section 2220.24, is limited to a specifically named sickness, its limit is less than $1,000 or the expenses for which it is payable are limited to those incurred within a period of less than six months following the commencement of any one period of sickness; or

(c) Payments for the expenses of each separate accident or period of sickness are subject to a deductible amount in excess of ten percent of the maximum benefit.

§ 2220.21. Basic Scheduled Surgical Benefits.

A basic surgical benefit in which surgical operations are listed by name or description with a limiting amount on each item shall be deemed not sufficient to be of real economic value to the insured if the amount provided for the most severe operation is less than $300.00 and the amounts provided for other operations are not reasonably related to such maximum amount and if it fails to contain a proviso that any operation not named and not otherwise excluded will be paid for in an amount which shall be objectively determined by the company on the basis of the gravity and severity of the unnamed operation as compared to analogously named operations.

§ 2220.22. Basic Pregnancy or Maternity Benefits.

A separate benefit for pregnancy, childbirth or miscarriage, when expressed as a specified dollar amount shall be deemed not sufficient to be of real economic value to the insured if its amount is less than $75.00 for normal delivery and $50.00 for miscarriage during the first policy year and less than $150.00 for normal delivery and $75.00 for miscarriage during subsequent policy years.

§ 2220.23. Basic Medical Service Benefits.

A benefit for expenses incurred for professional calls of doctors, covering home, office and hospital calls or one or more of such types of calls, shall be deemed not sufficient to be of real economic value to the insured if:

(a) More than the first three home calls, the first three hospital calls, or the first three office calls as the case may be, (counting as a call for such purpose at least one such call actually made during any one twenty–four hour period), are eliminated from the benefit; or

(b) The benefit limits payment for call made and otherwise compensable to fewer than one per twenty–four hour period; or

(c) The amount payable per compensable call is less than $6.00 per home call and less than $6.00 per office or hospital call; or

(d) Compensation provided for expenses of covered calls (whether resulting from each separate accident or sickness or occurring in each separate policy year) is limited:

(1) To a number less than 30 where the limit of such coverage is expressed in terms of number of calls, or

(2) To an amount less than $180.00 where the limit of such coverage is expressed in terms of a stated amount.

This section does not prohibit a provision which provides that physician's calls are not covered for a period after a surgical procedure is performed if the policy form provides a surgical benefit for the surgical procedure performed.

DREAD DISEASE BENEFITS

§ 2220.24. Dread Disease Benefits.

A sickness benefit which is limited to a delineated or defined field of sickness coverage (such as poliomyelitis, cancer or a specifically named or described disease) shall be deemed not sufficient to be of real economic value to the insured if:

(a) Its maximum limit is less than $10,000, or if the expenses for which it is payable are limited to those incurred for treatment necessitated by each such sickness within a period of less than three years following the commencement of medical treatment for such sickness, or if the benefits are subject to scheduled inside dollar limits and such limits do not meet the minimum requirements of Section 2220.25; or

(b) In lieu of the minimum benefits specified in paragraph (a) above, a policy or rider limited to cancer provides minimum benefits not less than the following: $50 a day for the first 12 days of hospitalization without any elimination period, deductible or coinsurance factor and also $30 a day for each day of continuous hospitalization thereafter with no limit on the number of days of hospitalization; X–ray, radium and cobalt therapy up to a total of $1,500; attending physician's charges in hospital (other

than the operating surgeon) of $7.50 per day up to a total of $500; surgical charges in accordance with the 1964 California Relative Value Schedule; anesthetist services either up to $100 for an operation other than for a skin cancer operation for which the anesthetist fee shall be not less than $30 for an operation or in an amount consistent with the amount provided by the 1964 California Relative Value Schedule; nursing expenses of $24 per shift for not less than one shift per day up to a total of $750; blood transfusions and plasma up to a total of $500; prescribed drugs and medicines up to a total of $250; and an overall aggregate limit on all benefits of not less than $10,000.

MAJOR MEDICAL EXPENSE BENEFITS

§ 2220.25. Major Medical Expense Benefits.

A policy, or rider, shall be deemed to provide major medical expense benefits and shall be deemed to be of real economic value and not subject to Section 2220.15 through 2220.24 if:

(a) The aggregate maximum benefit is not less than $10,000 per covered person.

(b) The coinsurance percentage applicable to expenses covered under Items (f), (g), (h), (i) and (j) below is not more than 25 percent, and the coinsurance percentage applicable to Item (k) and any other covered expense not referred to in this section is not more than 50 percent.

(c) The deductible amount (other than as specified below in this section) is not more than 10 percent of the maximum benefit.

(d) The maximum benefit period for an "each cause" type of policy (where a separate deductible is required for different sicknesses and accidents) is not less than 18 months and the maximum benefit period for an "all cause" type of policy (where separate deductibles are not required for different sicknesses or accidents) is not less than the number of days remaining in the calendar or policy year after the deductible has been met.

(e) The period allowed to satisfy the deductible is not less than 90 days if the deductible is $500 or less, or is not less than 90 plus an additional 30 days for each additional $500, or fraction thereof, of deductible.

(f) Hospital room and board expenses are covered, prior to application of the coinsurance percentage, for not less than $50.00 daily (or in lieu thereof the cost of a semi–private room rate in the area where the insured resides), and is not less than either the cost or double the daily amount during confinement in the hospital's intensive care unit for up to 10 days.

(g) Miscellaneous hospital services are covered, prior to application of the coinsurance percentage, for an aggregate maximum of not less than $1,500.

(h) Surgical fees are covered, prior to application of the coinsurance percentage, to a maximum of not less than $750 for the most severe operation in accordance with a surgical schedule which otherwise meets the requirements of Section 2220.21; and anesthesia services are covered, prior to application of the coinsurance percentage, for a maximum of not less than 15 percent of the covered surgical fees, or, alternatively, if the surgical schedule is based on a California Relative Value Schedule, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule.

(i) Doctors visits are covered, in or out of the hospital, with minimum dollar amounts per visit, prior to application of the coinsurance percentage, equal to not less than $8.00 per visit, covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than $500.

(j) Out–of–hospital diagnostic X–rays and tests are covered, prior to application of the coinsurance percentage, for an aggregate maximum of not less than $500.

(k) Not fewer than three of the following additional benefits are covered, prior to application of the coinsurance percentage, for an aggregate maximum of not less than $1,000:

(1) In–hospital private duty registered nurse services.

(2) Convalescent nursing home care.

(3) Diagnosis and treatment by a radiologist or physiotherapist.

(4) Rental of special medical equipment, as defined by the insurer in the policy.

(5) Artificial limbs or eyes; casts, splints, trusses or braces.

(6) Treatment for functional nervous disorders, and mental and emotional disorders.

(7) Out–of–hospital prescription drugs and medications.

The deductible amount may be expressed as either: (1) a fixed dollar amount; or (2) the higher of a fixed dollar amount of basic deductible or the policy's covered charges paid by medical expense insurance; or (3) not more than $500 plus the policy covered charges paid by other medical expense insurance.

Notwithstanding the terminology of either this section, or any other section of this Article, this section shall not be interpreted in any manner which is or would be inconsistent with the provisions of any applicable section of the Insurance Code. A benefit under this section shall not be of real economic value to an insured person if any coinsurance percentage factor of the policy is applied as a reduction in benefits prior to application of any deductible.

If a policy, or rider, provides a fixed benefit (a benefit not subject to a coinsurance percentage) for any of the medical expenses referred to in (f), (h) or (i) above, a fixed benefit of 75 percent of the minimum covered charge specified in (f), (h) or (i) shall be acceptable; and, if coinsurance percentages of less than 25 percent are applicable, a lower covered charge will be acceptable if at least as much as 75 percent of the minimum covered charge specified in (f), (h) or (i).

CATASTROPHIC MEDICAL EXPENSE BENEFITS

§ 2220.26. Catastrophic Medical Expense Benefits.

A policy, or rider, shall be deemed to provide catastrophic major medical expense benefits, and shall be deemed of real economic value and not subject to Sections 2220.15 through 2220.24, if it would otherwise qualify as providing major medical expense benefits under Section 2220.25 and (1) has an aggregate maximum benefit of not less than $25,000 per covered person, and (2) includes benefits for all of the items listed in Section 2220.25 (k) (1) through (k) (6) for an aggregate maximum of not less than $5,000.

§ 2220.27. Deductibles and Coinsurance Prohibited Unless Specifically Permissible.

Except to the extent specifically provided otherwise in Sections 2220.7 through 2220.30, deductables and coinsurance percentage factors are prohibited by this Article unless the benefits provided are of real economic value and the use of other coinsurance percentage factors and deductibles are approved by the Commissioner in accordance with the procedure provided under Section 2220.7. The Commissioner shall consider under the provision of Section 2220.7 other deductibles and coinsurance percentage factors for basic hospital, medical and surgical coverages provided that the benefits, in the opinion of the Commissioner, are not less than the actuarial equivalent for a covered person of the minimum benefits specified in this Article for the same type of benefit.

§ 2220.28. Recurrent Confinements and Recurrent Disabilities.

A policy may contain provisions relating to recurrent confinements or recurrent disabilities, provided however, a recurrent confinement provision or a recurrent disability provision shall be deemed not sufficient to be of real economic value to the insured if in applying any two or more periods of confinement or disability the periods of confinement or disability must be separated by more than 6 months.

INSURANCE ISSUED TO PERSONS ELIGIBLE FOR BENEFITS UNDER MEDICARE

§ 2220.29. Hospital Indemnity Policies.

A daily hospital benefit, provided on other than an expense incurred basis and issued to a person eligible for benefits under Medicare, shall be deemed not sufficient to be of real economic value to the person insured if:

(a) It provides a daily hospital benefit of less than $15, payable for less than 60 days, or if it is a hospital benefit for mental disorders, and the period of time the benefit is payable than 30 days; or

(b) The elimination period, if any, exceeds one day for sickness benefits and one day for accident benefits; or

(c) The benefits is subject to any waiting period other than a waiting period for condition specified in Section 2220.10(b); or

(d) It excludes coverages or provides reduced benefits for exceptions, limitations or reductions other than those specified in Section 2220.8; or

(e) It contains a pre–existing condition provision other than as specified in Section 2220.52(a).

A hospital indemnity policy conforming to this Section may not be labeled or described as a Medicare Supplement Policy.

NOTE: Authority cited: Section 10291.5(c), Insurance Code. Reference: Section 10291.5(b) (7), Insurance Code.

HISTORY

1. Amendment filed 4–5–78; effective thirtieth day thereafter (Register 78, No. 14).
2. Amendment of subsection (e) filed 3–31–83; effective thirtieth day thereafter (Register 83, No. 14).

§ 2220.30. Medicare Supplement Expense Policies.

NOTE: Authority cited: Section 10291.5 (c), Insurance Code. Reference: Section 10291.5 (b) (7), Insurance Code.

HISTORY

1. Amendment filed 4–5–78; effective thirtieth day thereafter (Register 78, No. 14).
2. Repealer filed 3–31–83; effective thirtieth day thereafter (Register 83, No. 14).

§ 2220.31. Prior Inconsistent Regulations and Bulletins Superseded.

This regulation supersedes all prior regulations and bulletins of this Department to the extent that such prior regulations and bulletins are inconsistent with this regulation.

Article 1.6. Medicare Supplement Coverage

§ 2220.50. Purpose and Scope.

This Article establishes minimum benefit and policy provision standards for Medicare supplement coverages which are equal to or exceed those applied in the voluntary certification of such coverages by the United States Secretary of Health and Human Services pursuant to Public Law 96–265.

It shall apply to all individual and group Medicare supplement insurance policies and non–profit hospital service plan benefit agreements approved by the Commissioner after its effective date its effective date. Pursuant to Insurance Code Section 10195, this Article also applies to all certificates providing Medicare supplement coverage issued to California residents pursuant to master policies delivered outside of California.

NOTE: Authority cited: Sections 10291.5 (c) and 10195, Insurance Code. Reference: Sections 10195 and 10291.5(b) (7), Insurance Code.

HISTORY

1. New Article 1.6 (Sections 2220.50—2220.57) filed 3–31–83; effective thirtieth day thereafter (Register 83, No. 14).

§ 2220.51. Definition.

"Medicare Supplement Coverage" is accident and sickness insurance which is designed primarily to supplement Medicare, or is advertised, marketed, or otherwise purported to be a supplement to Medicare and which meets the requirements of the following rules and standards applicable to any such insurance sold to a person eligible for Medicare by reason of age. It includes any individual, family, selected group ("franchise") or group disability insurance policy (and certificate) issued in this state, any certificate delivered in this state pursuant to a group master policy issued in another state, and any individual, family or group benefit agreement issued by a non–profit hospital service plan. It excludes group policies issued to one or more employers or labor organizations, or to the trustees of a fund established by one or more employers or labor organizations, or combinations thereof, for employees or former employees, or combinations thereof, for employees or former employees, or combinations thereof, of the labor organization. It also excludes individual policies or contracts issued pursuant to a conversion privilege in a policy or contract of group or individual insurance when the group or individual policy contract includes provisions which are inconsistent with the requirements of this Article.

NOTE: Authority cited: Section 10291.5(c), Insurance Code. Reference: Sections 10195 and 10291.5 (b) (7), Insurance Code.

§ 2220.52. General Policy Provisions.

The following shall be applicable to "Medicare Supplement Coverage" and shall be in addition to the requirements of Article 1.5, above. These are minimum standards and do not preclude the inclusion of additional benefits in such coverages:

(a) Pre–existing condition limitations shall not exclude coverage for more than six months after the effective date of coverage under the policy for a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effect date of the coverage;

(b) The term "Medicare benefit period"shall mean the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A Medicare hospital insurance;

(c) The term "Medicare eligible expenses" shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims;

(d) The term "Physician" shall mean a licensed practitioner of the healing arts, practicing within the scope of his or her license. It includes all practitioners described in Insurance Code Section 10176.

(e) The term "nurse" shall mean a registered nurse (R.N.) or a licensed vocational nurse (L.V.N.).

(f) The term "Medicare" shall mean the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

(g) The terms "Medicare Supplement," "Medigap" and words of similar import shall not be used to describe a policy unless the policy is issued in compliance with this Article.

(h) Coverage, when issued, shall not be subject to any exclusions, limitations, or reductions (other than as permitted in this Article and other applicable laws and regulations) which are inconsistent with the exclusions, limitations, or reductions permissible under Medicare, other than a provision that coverage is not provided for any expenses to the extent of any benefit available to the insured person under Medicare.

(i) Coverage shall not idemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(j) Coverage shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co–payment percentage factors; and

(k) Policies providing convalescent or extended care benefits shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital, nor shall they require a hospital confinement exceeding three (3) days.

NOTE: Authority cited: Sections 10291.5 (c) and 10195 (5) (b), Insurance Code. Reference: Section 10291.5(b) (7), Insurance Code.

§ 2220.53. Minimum Benefit Provisions.

Medicare Supplement Coverages shall provide at least the following benefits to an insured person:

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(c) Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

(d) Coverage of 20% of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5000 per calendar year.

NOTE: Authority cited: Section 10291.5(c), Insurance Code. Reference: Sections 10195 and 10291.5 (b) (7), Insurance Code.

§ 2220.54. Requirements for Replacement of Medicare Supplement Coverage.

(a) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in (c) below. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in (d) below.

(c) The notice required by (b) above for an insurer, than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (insert Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

[1] Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. Drafting Notes:

[a] Subsection [1] may be modified if pre-existing conditions are covered under the new policy.

[b] The term "Medicare Supplement Insurance" may be used in lieu of "Accident and Sickness Insurance."

[2] You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

[3] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical /health history.

Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(d) The notice required by (b) above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

[1] Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

[2] You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

[3] (To be including only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

NOTE: Authority cited: Section 10195(j), Insurance Code. Reference: Section 10195(j), Insurance Code.

§ 2220.55. Informational Brochure.

Insurers issuing policies which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person eligible for Medicare by reason of age, shall provide to the policyholder, a copy of the *Guide to Health Insurance for People with Medicare,* developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. Delivery of the Guide shall be made whether or not the policy qualifies as "Medicare Supplement Coverage" in accordance with Section 2220.51. Except in the case of a direct response insurer, delivery of the Guide shall be made at the time of application, and acknowledgment of receipt of certification of delivery of the Guide shall be provided to the insurer. Direct response insurers shall deliver the Guide upon request, but not later than at the time the policy is delivered.

NOTE: Authority cited: Section 10195(h), Insurance Code. Reference: Section 10195(h), Insurance Code.

§ 2220.56. Loss Ratios.

Policies to supplement Medicare shall develop loss ratios as follows: individual policies 60%, group policies 75%, subject to appropriate standards set forth in Article 1.9, Subchapter 2 of this Title.

NOTE: Authority cited: Section 10195(e), Insurance Code. Reference: Section 10193(a), Section 10195(e), Insurance Code.

§ 2220.57. Severability.

If any Section or portion of a Section of this Article or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this Article, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

NOTE: Authority cited: Section 10291.5(c), Insurance Code. Reference: Sections 10195 and 10291.5(b)(7), Insurance Code.

§ 2220.58. Annual Premium Rates and Loss Ratio Experience Filing Requirements for Medicare Supplement Insurance.

(a) This regulation applies to all insurers who offer Medicare Supplement Insurance, including pre-standardized Medicare Supplement Insurance plans, standardized Medicare Supplement Insurance plans, and Medicare SELECT plans, whether to individuals or groups.

(b) Annual premium rates and loss ratio experience filings must be made regardless of Medicare changes, an insurer's prior year loss ratio experience, future marketing plans, or whether new premium rates are being requested.

(c) Insurers offering Medicare Supplement Insurance must include the following in their annual filings with the Commissioner of Insurance:

(1) *Premium Rate Schedules.* Submit premium rate schedules for each individual policy or group certificate. Indicate all special rating factors used for California, such as a zip code rating factor. Indicate whether a premium rate change is requested and, if so, the percentage change.

(2) *Policy Forms.* Submit specimens of each individual Medicare Supplement Insurance individual policy or group certificate and outlines of coverage for each plan, if revised, new, or not included in a filing for a previous year.

(3) *Loss Ratio Experience Exhibits.* Provide complete loss ratio information for each Medicare Supplement Insurance plan since the inception of that plan. For rate filings made in anticipation of Medicare benefit changes, include at least nine months' of loss ratio experience (unless the plan has not been marketed for at least nine months, in which case, submit loss ratio experience information for the period the plan was marketed). First quarter filings must include the entire previous year's loss ratio experience. Such information for plans covering fewer than 100 California residents may be combined if the coverages are similar. Re-state the loss ratio information for the previous year, adjusted for run-off accruals to date. Include the number of California residents covered by the plan.

(4) *Projected Loss Ratio Experience.* Provide projected loss ratio experience for at least five years into the future, reflecting that projected experience both with and without any requested premium rate increase.

(5) *NAIC Medicare Supplement Experience Exhibit.* Provide a National Association of Insurance Commissioners (NAIC) Experience Exhibit for each individual policy form or group certificate which covers 100 or more California residents.

(6) *Actuarial Memorandum.* Submit an actuarial memorandum for each Medicare Supplement Insurance plan in accordance with subsection (d).

(d) Medicare Supplement Insurers must provide an actuarial analysis for each individual plan or group certificate that covers 100 or more California residents in an actuarial memorandum. More than one analysis can be combined in one memorandum. Once actuarial analysis may be provided for all individual plans or groups with certificates covering fewer than 100 California residents. Each insurer must use its own data; however, actuarial studies from other sources may be submitted to provide additional information regarding plan renewal assumptions.

Each actuarial analysis and memorandum must include:

(1) Historical and projected premium income, claims, and loss ratio experience for each plan.

(2) A description of coverage, including coverage renewability, whether marketing of the plan is continuing, the date marketing began, and the date marketing stopped, if it has stopped.

(3) For rate increase requests, the average current premium rate and the average premium rate for the proposed new premium rates for California residents, compared to the insurer's average premium rates for current and proposed new premium rates nationally.

(4) Active life reserves at the end of the prior calendar year.

(5) Monthly claim triangulation lag reports for California residents and nationally for the most recent 24 months for each plan or group policy covering 300 or more California residents. Circle or highlight the relevant data showing how the lag reports are used in developing incurred but not reported (IBNR) claims and claim reserves.

(6) A description of the experience and any premium rating request, including trend for benefits not covered by Medicare (*e.g.*, prescription drugs).

(7) National data and rating development presented in the same format as provided for California insureds.

(8) Cost trend assumptions.

(9) Administrative costs, including, but not limited to, commissions, claims processing, customer services, and taxes.

(10) A certification that the loss ratios comply with statutory requirements for loss ratios; and, if a premium rate increase is requested, that the loss ratios will continue to comply with such statutory requirements if a premium rate increase is approved.

(11) A certification that the filed rates are reasonable in relation to benefits provided for each individual policy form or group certificate.

(e) Completion and submission to the Commissioner of the documents and information required in subsection (b), (c), and (d) above, together with evidence that statutorily required minimum loss ratios are met constitutes the minimum standards necessary for approval of a Medicare Supplement Insurance premium rate filing.

NOTE: Authority cited: Section 10195.1(d), Insurance Code. Reference: Section 10195.1, Insurance Code.

HISTORY

1. New section filed 12-11-2000; operative 1-10-2001 (Register 2000, No. 50).

Article 1.7. Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act

§ 2221. Scope.

NOTE: Authority cited: Sections 790.10, 10195(a)(1), (b), (c), (e) and (g), 10291.5(c) and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10195(a)(3) and (f), 10290, 10291.5(b), 10606 and 10609, Insurance Code.

HISTORY

1. New section filed 11-10-88 as an emergency; operative 11-10-88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3-10-89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1-31-90 as an emergency; operative 1-31-90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5-31-90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1-22-91 (Register 91, No. 19).

§ 2221.1. Applicability.

NOTE: Authority cited: Sections 790.10, 10195(a)(1), (b), (c), (e) and (g), 10291.5(c) and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10195(a)(3) and (f), 10290, 10291.5(b), 10606 and 10609, Insurance Code.

HISTORY

1. New section filed 11-10-88 as an emergency; operative 11-10-88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3-10-89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1-31-90 as an emergency; operative 1-31-90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5-31-90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1-22-91 (Register 91, No. 19).

§ 2221.2. Definitions.

NOTE: Authority cited: Sections 790.10, 10195(a)(1), (b), (c), (e) and (g), 10291.5(c) and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sec-

tions 790.03(a) and (b), 10195(a)(3) and (f), 10290, 10291.5(b), 10606 and 10609, Insurance Code.

HISTORY

1. New section filed 11–10–88 as an emergency; operative 11–10–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–10–89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.3. Benefit Conversion Requirements.

NOTE: Authority cited: Sections 790.10, 10195(a)(1), (b), (c), (e) and (g), 10291.5(c) and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10195(a)(3) and (f), 10290, 10291.5(b), 10606 and 10609, Insurance Code.

HISTORY

1. New section filed 11–10–88 as an emergency; operative 11–10–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–10–89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.4. Form and Rate Filing Requirements.

NOTE: Authority cited: Sections 790.10 and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10606 and 10609, Insurance Code.

HISTORY

1. New section filed 11–10–88 as an emergency; operative 11–10–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–10–89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.5. Accelerated Policy Adjustment Approval Procedures.

NOTE: Authority cited: Sections 790.10, 10195(n) and 10606, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10195(a)(3) and (h) and 10606, Insurance Code.

HISTORY

1. New section filed 11–10–88 as an emergency; operative 11–10–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–10–89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.6. Offer of Reinstitution of Coverage.

NOTE: Authority cited: Sections 790.10, 10608 and 12921.3, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10195(a)(3), 10606 and 12921.3, Insurance Code.

HISTORY

1. New section filed 11–10–88 as an emergency; operative 11–10–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–10–89.
2. Repealed by operation of Government Code section 11346.1(g) (Register 90, No. 6).
3. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
4. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.7. Requirements for New Policies and Certificates.

NOTE: Authority cited: Sections 790.10, 10195(a)(1), (b), (c), (e), (g), 10291.5(c) and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 790.03(a) and (b), 10195(a)(3) and (f), 10290, 10291.5(b), 10606 and 10609, Insurance Code.

HISTORY

1. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
2. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.8. Filing Requirements for Advertising.

NOTE: Authority cited: Sections 10608, 10195.7, 790.10, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 10195.6, 10609 and 10606, Insurance Code.

HISTORY

1. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
2. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.9. Buyers Guide.

NOTE: Authority cited: Sections 10195(h), 790.10 and 10608, Insurance Code. Reference: 42 U.S.C. 1395ss; and Sections 10195(a)(3), 790.03(a) and 10606, Insurance Code.

HISTORY

1. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 6). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
2. Repealed by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

§ 2221.10. Separability.

NOTE: Authority cited: Section 10291.5(c), Insurance Code. Reference: Sections 10195 and 10291.5(b)(7), Insurance Code.

HISTORY

1. New section filed 1–31–90 as an emergency; operative 1–31–90 (Register 90, No. 5). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 5–31–90.
2. Repealed by operation of Government Code section 11346.1(g) filed 1–22—91 (Register 91, No. 19).

Article 1.8. Medicare Supplement Insurance—Compliance with Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203)

§ 2221.50. Participating Physician or Supplier Claims Form Requirements.

NOTE: Authority cited: Section 10195(b), Insurance Code. Reference: 42 U.S.C. 1395u(h)(3)(B) and 42 U.S.C. 1395ss; and Sections 10195(a)(1) and (b), Insurance Code.

HISTORY

1. New section filed 11–14–88 as an emergency; operative 11–14–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–14–89. For prior history of Article 1.8, see Register 77, No. 19.
2. Repealed by operation of Government Code Section 11346.1(g) (Register 90, No. 6).

§ 2221.51. Reporting Requirements.

NOTE: Authority cited: Sections 10195(b) and 10195(e), Insurance Code. Reference: 42 U.S.C. 1395u(h)(3)(B) and 42 U.S.C. 1395ss; and Sections 10195(a)(1), (b) and (e), Insurance Code.

HISTORY

1. New section filed 11–14–88 as an emergency; operative 11–14–88 (Register 88, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–14–89.
2. Repealed by operation of Government Code Section 11346.1(g) (Register 90, No. 6).

Article 1.9. Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable in Relation to the Premium Charged Pursuant to Subdivision (c) of Section 10293

§ 2222.10. Applicability.

This article is adopted pursuant to and in implementation of Section 10293(a) of the Insurance Code, is applicable to individual disability policies providing hospital, medical or surgical insurance coverages, as defined in Section 2222.11 herein, and mass-marketed policies as defined in Insurance Code section 10293(c)(1), that are either (1) delivered or issued for delivery to any person in this State on or after July 1, 2007, or (2) delivered or issued for delivery to any person in this State on or after July 1, 1962 and subject to any rate revision effective on or after July 1, 2007, and relates to standards by which the Insurance Commissioner shall withdraw approval of policy forms the benefits of which are unreasonable in relation to the premiums charged.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. New Article 1.9 (Sections 2222.10 through 2222.19) filed 12-12-62; effective thirtieth day thereafter (Register 62, No. 25).
2. Amendment filed 5-6-77 as procedural and organizational; effective upon filing (Register 77, No. 19).
3. Amendment of section and NOTE filed 12-29-2006; operative 3-29-2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.11. Definitions.

(a) The term "hospital, medical or surgical policy" as used in this article means any disability insurance contract (whether composed solely of a policy or of a policy and one or more riders, endorsements, or amendments attached thereto) designed, constructed, advertised or sold as having as its dominant purpose the provision of benefits contingent upon the rendition of hospital, medical or surgical services. This definition includes a "mass-marketed policy," as described in Insurance Code section 10293. This definition also includes a policy of "health insurance" as described in Insurance Code section 106(b), but does not include supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less.

For purposes of this article, the phrase "dominant purpose" means any disability insurance contract (whether composed solely of a policy, or of a policy and one or more riders, endorsements, or amendments attached thereto) upon which at least 50 percent of the initial premium or of any renewal premium is or may be, under the underwriting rules or practices of the insurer, allocated or apportioned or should reasonably be allocated or apportioned to the hospital, medical or surgical benefits provided therein. In case of a "hospital, medical or surgical policy" which contains, in addition to benefits contingent upon the rendition of hospital, medical or surgical services, other benefits which are not subject to this article, the insurer may segregate the earned premiums and the incurred losses for those benefits which are subject to the provision of this article, and the commissioner may require such segregation if substantial benefits not subject to this article are provided. If there is no such segregation, the experience of the policy will be considered as a unit. This definition *shall not be construed* to include: (1) policies which provide a benefit expressed as an increase of a loss of time benefit during hospital confinement, which is not advertised or sold as a hospital benefit, or (2) a single premium nonrenewable transportation ticket policy having as its dominant feature the protection of the insured from a transportation hazard.

(b) The term "individual" policy as used in this article means a disability policy purporting to insure only one person, except that included within this definition shall be a family policy or family expense policy defined in Section 10320(c) of the Insurance Code.

(c) Policies "issued on a mass underwriting basis" as used in this article shall mean individual hospital, medical, or surgical policies (1) conforming to all of the underwriting and renewal conditions set forth in Section 10270.97 of the Insurance Code, relating to selected group disability insurance; or (2) issued without individual underwriting pursuant to the exercise of a conversion privilege in a group policy; or (3) issued at lower than the individual policy rates otherwise charged predicated on the expectation of substantial savings in operating expenses to members of a group of individuals (such as members of a professional association), under a plan or arrangement entered into between the insurer and the association; or issued on a mass enrollment basis to members of a defined group of individuals (such as residents over age 65 in one state) under a plan whereby the insurer will not discontinue, or modify rates of, any policy, unless it simultaneously discontinues or similarly modifies all other policies in the same group; or (4) at the discretion of the commissioner, any similar policy predicated upon substantial savings in operating expense arising from mass enrollment.

(d) The terms "premiums earned" and "losses incurred" as used in this article shall be developed by a method consistent with that method used for developing such items in Schedule H of the life and accident and health annual statement blank, unless otherwise specifically indicated in this article.

(e) References to specified portions of annual statement blanks shall apply to all amendments and additions or successor provisions hereafter made.

(f) "Rate revision" means a change in premium rates that applies to existing policies.

(g) "Lifetime anticipated loss ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred claims since the inception of the policy and the present value of future anticipated claims, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premiums earnings.

(h) "Disease management expenses" means expenses incurred by an insurer for services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based guidelines and patient self-management strategies.

(i) "Lifetime anticipated disease management ratio" means the ratio of (i) divided by (ii), where (i) is equal to the sum of the accumulated value of past incurred disease management expenses since the inception of the policy and the present value of future anticipated disease management expenses, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premium earnings.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Amendment of subsection (a) and new subsections (f)-(i) and NOTE filed 12-29-2006; operative 3-29-2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.12. Standards of Reasonability.

The authority of the commissioner under Insurance Code Section 10293 being to withdraw approval of policy forms the benefits of which are not reasonable in relation to the premium charged, whether the approval of any form of an insurer should be withdrawn pursuant to said section shall be determined by an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop. Some of such factors which will be considered by the commissioner are hereinafter in this article set forth, but their listing does not preclude an insurer from urging any other factors which it considers relevant to the issue involved.

(a) Benefits provided by a hospital, medical or surgical policy shall be deemed to be reasonable in relation to premiums if either (1) the lifetime anticipated loss ratio is not less than 70%, and (2) in the case of a rate revi-

sion, the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage is also not less than 70%, or, if the insurer chooses to include disease management expenses in determining compliance with these standards, (3) the sum of the lifetime anticipated less ratio and the lifetime anticipated disease management ratio is not less than 70%, and (4) in the case of a rate revision, the sum of the anticipated less ratio over the future period for which the revised rates are computed to provide coverage and the anticipated disease management ratio over the future period for which revised rates are computed to provide coverage is also not less than 70%.

(b) Benefits provided by a hospital, medical, or surgical policy delivered or issued for delivery to any person in this State prior to July 1, 2007 and not subject to any rate revision effective on or after July 1, 2007 shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(c) Benefits provided by supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less shall be deemed to be reasonable in relation to premiums if the lifetime anticipated loss ratio is not less than 50%.

(d) Benefits provided by a hospital, medical or surgical policy designed to supplement Medicare, as defined in subdivision (*l*) of Insurance Code section 10192.4, must meet the loss ratio standards established in Subdivision (a)(1)(A) of Section 10192.14 of the Insurance Code.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Amendment filed 4–5–78; designated effective 1–1–79 (Register 78, No. 14).
2. Amendment filed 3–31–83; effective thirtieth day thereafter (Register 83, No. 14).
3. Amendment of section and NOTE filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.13. Preliminary Screening Procedure.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Repealer filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.14. Credibility Factors.

The commissioner may consider the use of credibility factors consistent with sound actuarial principles in the review of experience to recognize deviations from the loss ratio standard that may be due to chance variation.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Repealer of section and new section and NOTE filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.15. Communication to Insurer.

Prior to taking any action under Section 2222.17, the commissioner will communicate with the insurer in writing, identifying those policies for which any preliminary review does not establish an inference that the benefits provided therein are reasonable in relation to the premium charged. Such communication shall be deemed confidential, and shall advise the insurer that it should inform the commissioner as to any factors applicable to the consideration of the policy under review which it considers relevant to the reasonableness of the relationship of benefits to premiums. The insurer may, from time to time, submit supplementary material which it deems to be relevant to the study of the loss ratios generated by a specific policy; and the commissioner may request such additional information as he may deem necessary to complete his consideration of such policy.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Amendment of section and new NOTE filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.16. Consideration of Relevant Factors.

In reviewing any specific policy the commissioner shall consider all factors as are relevant to a determination as to whether the benefits are unreasonable in relation to the premium charged therefor. Relevant factors and the weight to be given thereto depend upon the attributes of such particular policy, as determined by the commissioner in accordance with the provisions of this article. The following is a list of relevant factors which are generally applicable to policies subject to this statute:

(a) Policy experience generated over the period of the one preceding calendar year (ending with the beginning of the year of review) in addition to the year of review may be considered as relevant in case of any policy form. Experience generated over a still longer period (ending with the year of review) may be considered in case of any policy as to which there are substantial reasons to believe, insofar as loss experience is relevant to the issue to be determined, that the experience statistics for the shorter period do not give a fair indication of the actual loss experience of the policy under review. Experience over such extended periods can be considered only if relevant experience figures are made available to the commissioner.

(b) Adjustment of experience statistics to conform to assumption of payment of premiums annually in advance. The adjustment will be that the annual premium shall be deemed to be an amount which is:

(1) 96 percent of the sum of semiannual premiums;

(2) 94 percent of the sum of quarterly premiums; or

(3) 92 1/2 percent of the sum of monthly premiums.

If the insurer desires consideration of the increase in handling expenses arising from fractional premium payments, the insurer must furnish for the experience period (i) the distribution of earned premiums according to mode of premium payment during the year, and (ii) adjusted experience statistics based upon conforming earned premiums related to premiums collected semiannually, quarterly, monthly, and upon a weekly and monthly debit basis to the earned premiums developed from the corresponding pro rata annual premium.

(c) Effect of any premium rate changes made during the experience period under review. In order that the commissioner may properly evaluate this factor, the insurer must furnish complete data thereon, including adjusted experience statistics in which earned premiums are adjusted to conform with the current rate basis.

(d) The effect of any experience refunds or dividends paid to policyholders. Insurers desiring consideration of this factor should furnish particulars with respect to such amount accrued for the period of review together with adjusted experience statistics in which such refunds or dividends are considered as a reduction of premiums earned.

(e) With respect to a policy not subject to the reserve requirements of Insurance Code Section 997(b), the loss ratio experienced and reasonably anticipated by policy year; and, where appropriate, the aggregate loss ratio excluding the first policy year. In order that the commissioner may properly evaluate these factors, the insurer must furnish in conjunction therewith data as to the persistency experienced and reasonably anticipated on the policy under review, together with a weighted average loss ratio computed over a reasonable period of time giving effect to these factors. Such weighted average should be based on the experience reasonably to be anticipated in the light of persistency actually experienced and other circumstances likely to affect future persistency. The insurer may also furnish other data relating to actuarial assumptions relevant to the experience to be expected on the policy.

(f) With respect to a policy subject to the reserve requirements of Insurance Code Section 997(b), the insurer should submit for consideration an adjusted loss ratio for the experience period based on the formula given in the footnote to Schedule H in the Life and Accident and Health Annual Statement blank relating to the development of a supplemental loss ratio for individual noncancelable accident and health policies which takes into account the reserves held pursuant to Section 997. If such ad-

justed loss ratio, after giving effect to such other factors as may be relevant, does not establish the reasonableness of benefits to premiums, the insurer must furnish an analysis of the relation of actuarial net annual premium rates for the policy to the corresponding gross annual premium rates established by the insurer. Such net premiums may be determined on a basis consistent with the minimum valuation standards set forth in Section 997(b) or on an appropriate alternate basis permitted by Section 997 provided details of the actuarial assumptions used are furnished the commissioner. In order that the commissioner may properly evaluate this factor, the insurer may also be required to submit an actuarial analysis of the relation of the actual morbidity experience under the policy to the assumptions used in determining the net premium rates, with an estimate of the extent of the change in the net premium rates indicated by such actual experience, with due allowance for reserves held pursuant to Section 997.

(g) Experience in any areas where different rate levels were in effect as compared with the countrywide experience on such policy of the insurer in any case in which it can be shown that such experience differs significantly from such countrywide experience.

(h) The likelihood of fluctuation in experience under the policy because of infrequency of loss occurrence or catastrophic nature of hazard covered. Insurers requesting consideration of this factor should furnish appropriate data as requested.

(i) Establishment of credibility of loss ratio experienced on policy under review, based upon available data to be furnished by the insurer for the experience period as to volume of premiums earned, average premium paid per person insured for one year's coverage, average amount of loss per claim incurred, and distribution of claims incurred by size of claim.

(j) With respect to any policy under review the commissioner may on his own initiative or at the request of the insurer consider experience and other factors on other policy forms to the extent they are relevant to determination of the reasonableness of benefits to premium; in particular, such aggregate or averages as may serve to show the reasonableness of benefits to premiums on a class of business as a whole of which the policy under review is a part.

(k) When in connection with the consideration of any policy it is established that there is a trend upward or downward in the loss experience for the type of benefits provided therein, consideration may be given to the probable effect of such trend factor on the loss experience reasonably to be anticipated under such policy.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Amendment of subsections (b)(2)–(3), repealer of subsection (b)(4) and new NOTE filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.17. Notice to Insurer.

If after consideration of all relevant factors the commissioner believes that the benefits provided under an individual hospital, medical or surgical policy are not reasonable in relation to the premium charged, the commissioner shall so inform the insurer in writing. Such notification shall be deemed a confidential communication. The commissioner shall also advise the insurer that the commissioner will, at the commissioner's discretion, commence proceedings for withdrawal of authorization of the form after notice and hearing as provided by law unless, within 31 days from the date of the notification, the insurer commits itself in writing to the commissioner that it will, within 90 days, voluntarily either (1) cease further issuance of the policy form or (2) increase benefits under the policy in relation to the premiums charged in an amount sufficient to bring the policy into compliance with the standards of reasonability provided for in section 2222.12. If the insurer does not commit itself, within 31 days from the date of the notification, to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings at any time as provided by law for withdrawal of the authorization of the policy form.

NOTE: Authority cited: Section 10293, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. Amendment of section and new NOTE filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

§ 2222.18. When Resubmission Deemed to Be Same as Withdrawn Policy.

The commissioner may consider two or more forms of the policy contracts as prepared by any one insurer or two or more affiliated insurers as one policy form for the purpose of determining under the provisions of this article whether benefits are reasonable in relation to premiums if the benefits and premiums or premium rates of such policy forms are alike in substance. Any policy form submitted by an insurer to replace a form of itself or its affiliates, the approval of which has been withdrawn under the provisions of this article, shall not be considered to be a new form or a form different from that of the form the approval of which was withdrawn, unless the benefits of the new form are sufficiently more favorable to the insured, or the premium or premium rates are sufficiently lower so as to indicate that the new form will meet the tests of this article.

§ 2222.19. Statement of Compliance.

Unless requested by the commissioner to provide more specific information on policy forms subject to the standards of reasonability in Section 2222.12, a company shall, by April 1 of each year, provide a statement from a qualified actuary that lists the policy forms to which the standards apply, the lifetime anticipated loss ratio and, if applicable, the lifetime anticipated disease management ratio for each form, and a statement that the standards of reasonability have been met, for each policy form for the preceding calendar year. For policy forms to which Section 2222.12(a) applies, a company shall also submit by April 1 of each year a schedule detailing disease management expenses for the preceding calendar year, if applicable.

NOTE: Authority cited: Sections 10293 and 10608, Insurance Code. Reference: Section 10293(a), Insurance Code.

HISTORY

1. New subsection (5) filed 4–5–78; designated effective 1–1–79 (Register 78, No. 14).
2. Amendment of section heading, repealer and new section and amendment of NOTE filed 12–29–2006; operative 3–29–2007 pursuant to Insurance Code section 10293(a) (Register 2006, No. 52).

Article 2. Group Disability Policies

NOTE: Authority cited: Section 10270.93, Insurance Code. Reference: Sections 10270–10278, Insurance Code.

HISTORY

1. Repealer of Article 2 (Sections 2223 through 2232) filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19). For prior history, see Registers 3; 10, No. 5; and 20, No. 5.

Article 2a. Group Disability Policies

GENERAL INSTRUCTIONS AND RULES

§ 2232.1. Applicability.

This article is applicable to all group disability insurance policies delivered or issued for delivery in this State on or after January 1, 1957, and to all such policies which the issuing insurer elects, before that date, to draft in compliance with the requirements of this article in lieu of incorporating therein the standard provisions promulgated for group disability policies as set forth in Article 2 of this subchapter. No group disability policy may be issued hereafter and until January 1, 1957, unless it contains, in accordance with the instructions for their use, either the standard provisions set forth in Article 2 of this subchapter or the uniform provisions set forth in this article. (Ins. C. 10270.94).

NOTE: Authority cited for Article 2a (Sections 2232.1 through 2232.41), Section 10270.94 Insurance Code.

HISTORY

1. New Article 2a (Sections 2232.1 through 2232.41) filed 4–4–56; effective thirtieth day thereafter (Register 56, No. 6).

§ 2232.2. Provisions Required.

Every group disability policy subject to this article which is delivered or issued for delivery in this State shall contain certain uniform provisions which shall be set forth in the policy in accordance with the requirements and provisions of this article. (Ins. C. 10270.9.)

§ 2232.3. Required Changes in Uniform Language.

If any compulsory or optional uniform provision set forth in Section 2232.8 or in Sections 2232.16 to 2232.40, inclusive of this article is in whole or in part inapplicable to or inconsistent with the coverage provided in the policy, the insurer shall, with the approval of the commissioner, either omit entirely from the policy or modify any inapplicable provision or alternative provision, or shall modify any inconsistent provi-

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sion or alternative provision in such manner as to make the provision as contained in the policy consistent with the coverage so provided. (Ins. C. 10323.)

§ 2232.4. Order of Uniform Provisions.

The compulsory and optional uniform provisions set forth in Section 2232.8 or Sections 2232.16 to 2232.40 of this article, or any corresponding provisions which are used in lieu thereof in accordance with this article, shall, in accordance with the instructions for their use, be set forth in the consecutive order in which the compulsory and optional uniform provisions are hereinafter set forth in Sections 2232.16 to 2232.40 of this article, or at the option of the insurer any such provision may appear as a unit in any part of the policy with other provisions with which it may be logically related, providing the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead the policyholder or any person insured thereunder. (Ins. C. 10324.)

§ 2232.5. Explaining Variations in Order and Wording.

If any group disability policy subject to this article submitted for approval sets forth the uniform provisions therein in any order or under any captions other than in the order or alternative order and under the captions or alternative captions as set forth in or specifically permitted by this article, or if any language for any of said uniform provisions is used other than the language or alternative language of the uniform provisions set forth in this article with only such changes therein as may be necessary to make such language harmonize with the terminology and the benefits of the policy, then in such case, the insurer in its letter submitting any such form, shall point out each such variation of order, caption or language, explaining the differences therein from the order, caption or language, as the case may be, prescribed by this article, the reason therefor, and why the insurer believes the order, caption or language of the provision as set forth in the policy is, in each case, not less favorable to the policyholder or any individual insured under the policy than the order, caption or language of the corresponding provision as prescribed by this article. (Ins. C. 10327.)

§ 2232.6. Compliance with Uniform Provisions.

No group disability policy provision which is not a subject of Sections 2232.16 to 2232.40, inclusive, of this article shall make any policy subject to this article or any portion thereof less favorable in any respect to the policyholder, to any person insured thereunder or to any beneficiary than the provisions which are subject to this article. (Ins. C. 10328.)

§ 2232.7. Alternative Permissible Order.

Alternative permissible orders, groupings and captions for the uniform provisions prescribed by this article without obtaining the prior approval of the commissioner as provided in Section 2232.5 are as hereinafter set forth in this section. If, in accordance with any of the alternatives hereinafter set forth in this section, more than one of the uniform provisions are grouped together under a principal caption, such uniform provisions shall nevertheless be set forth in the policy in their relative orders as set forth in this article, unless any such variation in order is noted, explained and approved by the commissioner as is required for other variations in order. The alternatives hereinabove referred to are as follows:

(a) The uniform provisions captioned "Notice of Claim," "Claim Forms" and "Proofs of Loss" may be grouped together under a principal caption such as "Notice and Proof of Claim" or "Notice and Proof of Loss," but each uniform provision shall be preceded and identified by its individual caption or subcaption.

(b) The uniform provisions captioned "Time of Payment of Claim" and "Payment of Claims" may be grouped together under a principal caption "Payment of Claim," "Payment of Loss" or "Payment of Benefits," but each uniform provision shall be preceded and identified by its individual caption or subcaption. The uniform provision captioned "Payment of Claims" may be set forth with the short form of proof of claim in accordance with Section 2232.8 hereof.

(c) The uniform provisions covered in paragraphs (a) and (b) above may be grouped together under a principal caption identifying the provisions as relating to notice, proof and payment of claim appropriately combining a caption permitted by paragraph (a) with caption permitted by paragraph (b) but each individual uniform provision shall be preceded and identified by it's individual caption or subcaption.

(d) The uniform provision captioned "Physical Examination and Autopsy" may be included with the uniform provisions covered in paragraph (a) or in paragraph (c) hereof, and under one of the principal captions therein permitted, but each uniform provision shall be preceded and identified by its individual caption or subcaption.

(e) The insurer may set forth the optional uniform provision captioned "Reduced Hospital Benefits in Case of Coverage Under the California Unemployment Insurance Code" in the policy as a separate uniform provision under its proper caption, or the insurer may set forth the substance or effect of such provision in the policy as a part of the statement of the hospital benefits in conformity with the instructions for its use, in which case a separate caption or subcaption for the uniform provision is not required.

(f) The uniform provisions captioned "Entire Contract; Changes," "Time Limit on Certain Defenses," "Grace Period," "Legal Actions" and "Changes of Beneficiary" may be set forth in the policy separately under their individual captions, or they may be grouped in whole or in part under an appropriate principal caption, or may be set forth with other provisions of the policy with which they are logically related subject to the requirements of identical in Section 2232.5 hereof, but said provider provisions or the variations hereof.

(1) The uniform provision captioned "Entire Contract; Changes" may be set forth in the policy on the first page thereof with the insuring, consideration or execution clauses, in which case the separate caption for the uniform provision is not required; or said uniform provision may be set forth in the policy under some principal caption such as "Contract Provisions" along with the uniform provisions captioned "Time Limit on Certain Defenses" and "Legal Actions," but each uniform provision shall, in such case, be preceded and identified by its individual caption or subcaption.

(2) The uniform provision captioned "Time Limit on Certain Defenses" may be set forth in the policy on the first page thereof with the caption or subcaption with the uniform provisions covered by paragraph (b) hereof, or may be set forth with the uniform provision captioned "Legal Actions" under an appropriate principal caption such as "Time Limits on Legal Actions and Certain Defenses," in which case a separate caption or subcaption for the uniform provisions is not required.

(3) The uniform provision captioned "Grace Period" may be set forth in the policy with the provision thereof relative to payment of the premium by the employer, in which case a separate caption or subcaption for the uniform provision is not required if the caption for the combined provisions includes mention of a grace period.

(4) The uniform provision captioned "Change of Beneficiary" may be set forth in the policy along with the provisions thereof relative to the designation of beneficiary by the employee, in which case a separate caption or subcaption for the uniform provision is not required if the caption for the combined provisions includes mention of change of beneficiary. (Ins. C. 10327.)

§ 2232.8. Short Form of Proof of Claim.

As another alternative permissive order and wording for setting forth in a group disability policy certain of the uniform provisions, the insurer may, in lieu of using the promulgated order and wording of the uniform provisions captioned "Notice of Claim," "Claim Forms," and "Time of Payment of Claim," and at the option of the insurer, also in lieu of one or more or all of the uniform provisions captioned "Proof of Loss," "Physical Examination and Autopsy" and "Legal Actions," but subject to the instructions hereinafter set forth, use the following short form of proof of claim clause under one of the captions permitted by the instructions hereinafter set forth:

All ("benefits" or other descriptive phrase) provided in this policy shall be paid to the employee as they accrue or as stated (referring to the location in the policy of the uniform provision captioned "Payment of Claims") upon receipt of written proof on the insurer's forms or, if such forms are not furnished by the insurer within 15 days after demand therefor, then upon receipt of written proof covering the occurrence, character and extent of the event for which claim is made.

Instructions

1. The above provision shall be preceded by a caption reading "Proof of Claim" or "Proof of Loss"; but if the uniform provision captioned "Payment of Claims" has either been omitted in accordance with Instruction 2, or if said uniform provision is set forth, in accordance with the instructions for its use, immediately following this provision, then such provision or provisions may be preceded by the caption "Payment of Benefits" or "Payment of Claims."

2. The insurer shall omit the phrase "or as stated_____" if the uniform provision captioned "Payment of Claims" is entirely omitted from the Policy in accordance with the instructions for its use. The insurer shall include said phrase in the policy even if it uses only the second or third or the second and third paragraphs of the uniform provision captioned "Payment of Claims" in the policy.

3. The insurer has the option of including or omitting the language in the above provision concerning the forms for proof of loss reading "on the insurer's forms or, if such forms are not furnished by the insurer within 15 days after demand therefor, then upon receipt of written proof."

4. The insurer has the option of including in, or omitting from the policy the uniform provision captioned "Proof of Loss," but if said provision is omitted the insurer shall also omit the uniform provision captioned "Legal Actions." However, if said Uniform Provision captioned "Proof of Loss" is included in the policy, the Uniform Provision captioned "Legal Actions" may either be included or omitted from the policy.

5. The insurer has the option of including or omitting the uniform provision captioned "Physical Examination and Autopsy." (Ins. C. 10270.94.)

§ 2232.9. Order Conforms to Insurance Code.

The compulsory and optional uniform provisions for group disability insurance are set forth in this article in the order in which the corresponding provisions are set forth in the Insurance Code, and for purposes of identification and uniform reference, they are given substantially the same captions as the corresponding provisions in the Insurance Code. (Ins. C. 10270.94.)

§ 2232.10. Provisions Contain Instructions.

Following each of the compulsory and optional uniform provisions set forth in this article are instructions for their use. In case no uniform provision corresponding to a particular provision as set forth in the Insurance Code is set forth in this article, the instructions indicate the rules with respect to the subject matter of that uniform provision which must be conformed to in all group disability policies subject to this article. (Ins. C. 10270.94.)

§ 2232.11. Designation of Matters to Be Omitted or Added.

Unless the context otherwise requires, portions of provisions enclosed in parentheses may be or are required to be omitted or added under the circumstances specified in the instructions for the use of that particular uniform provision. (Ins. C. 10270.94.)

§ 2232.12. "Insurer" Includes.

Whenever the word "insurer" is used in a uniform provision, there may be substituted therefor "company," " corporation," "association... society," or such other word or words as will properly designate the insurer. (Ins. C. 10270.94.)

§ 2232.13. "Policy" Includes.

Whenever the word "policy" is used in this article reference is made to all riders, endorsements, or other forms which constitute or form a part of the contract of group disability insurance. Whenever the word "policy" is used in any of the uniform provisions, there may be substituted therefor the words "rider," endorsement, "contract" or other proper designation of the document to which the uniform provision applies. Whenever in any form of uniform provision as set forth in this article the expression "the policy" or "this policy" is used, the terminology may be used interchangeably, with variations in the use of the term "policy" as herein permitted, insofar as consistent with the other terminology of the policy and the substantive meaning of the promulgated provisions. (Ins. C. 10270.94.)

§ 2232.14. "Employer" or "Policyholder" Includes.

Whenever the word "employer" or "policyholder" is used in this article, unless the text otherwise requires, reference is made to any person to whom or to which the policy is issued. Whenever the word "employer" or "policyholder" is used in any uniform provision, there may be substituted therefor the words "executive officer," "association," "trustee" or other proper designation of the person making application, if any, for the policy or to whom or to which the policy is issued. (Ins. C. 10270.94.)

§ 2232.15. "Employee" Includes.

Whenever the word "employee" is used in this article reference is made to any individual who has been, or is eligible to be insured under the policy with respect to himself, his spouse or dependents. Whenever the word "employee" is used in any uniform provision, there may be substituted therefor the word "member" or other proper designation of the individual, other than spouse or dependent, insured under a policy. (Ins. C. 10270.94.)

COMPULSORY UNIFORM PROVISIONS

§ 2232.16. Compulsory Uniform Provision Requirements.

Except as otherwise provided in Section 2232.1, each group disability policy delivered or issued for delivery to any person in this State shall contain the provisions or alternative provisions specified in Sections 2232.17 to 2232.28, inclusive, or in Section 2232.8 hereof in the words therein set forth, subject, however, to the "General Instructions and Rules" hereof and the instructions as to its use following each such provision; provided, nevertheless, that the insurer may at its option, subject to Section 2232.5 hereof, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner, which are in each instance not less favorable in any respect to policyholder, any individual insured or any beneficiary. Such provisions shall be preceded individually by the caption appearing herein as the caption for each such provision or by such caption and subcaption as is herein specifically permitted, or at the option of the insurer and subject to Section 2232.5 hereof, by such appropriate individual or group captions or subcaptions as the commissioner may approve. (Ins. C. 10350.)

§ 2232.17. Entire Contract; Changes.

Form A.

This policy and the application of the employer constitute the entire contract between the parties, and any statement made by the employer shall, in the absence or fraud, be deemed a representation and not a warranty. No statement made by any employee whose eligibility has been accepted by the insurer shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder.

Form B.

This policy constitutes the entire contract between the parties, and no statement made by the employer or by any employee whose eligibility has been accepted by the insurer shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder.

No change in this policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Form C.

This policy (the application of the employer, if any, and the individual applications, if any, of the employees) constitute(s) the entire contract be-

tween the parties, and any statement made by the employer or by any employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the employer, except a fraudulent misstatement, be used at all to void this policy after it has been in force for three years from the date of its issue, nor shall any such statement of any employee eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed herein or attached hereto. No agent has authority to change this policy or waive any of its provisions.

Instructions

1. The insurer may, at its option, use either Form A, Form B, or Form C.

2. If the insurer uses Form A, it shall use paragraph (a), or paragraph (b) of the "Time Limit on Certain Defenses" uniform provision as is required or permitted by the instructions for their use, but revised to eliminate all reference to the statements and applications of employees. Paragraph (c) of said uniform provision shall be used or omitted in accordance with the instructions for its use.

3. If the insurer uses Form B, it shall use neither paragraph (a) nor paragraph (b) of the "Time Limit on Certain Defenses" uniform provision, and it shall use or omit paragraph (c) of said uniform provision as required in accordance with the instructions for its use.

4. If the insurer uses Form C, it may, at its option, omit therefrom at the place indicated by parentheses in the first sentence reference to the applications of employees or the application of the employer, or both if it does not desire to make the application or applications, reference to which is omitted, a part of the policy. In such case proper connective words shall be used and the verb "constitute" made singular or plural to agree with the option selected by the insurer.

5. The insurer may, at its option, include or omit the words in parentheses in the first paragraph of Form A and Form B and in the second sentence of Form C reading, "avoid the insurance or reduce the benefits under this policy or."

6. The insurer may, at its option, substitute for the words "and unless such approval be endorsed hereon or attached hereto" at the end of the first sentence of the second paragraph of Form A, Form B, or Form C the words "and evidenced by endorsement hereon, or by amendment hereto signed by the employer and by an executive officer of the insurer."

7. The insurer may omit the portion of the first paragraph of Form C following the phrase "unless it is contained in a written application" if the insurer uses paragraph (a) or (b) of the uniform provision captioned "Time Limit on Certain Defenses" in accordance with the instructions for their use. (Ins. C. 10270.6 (a), 10350. 1.)

NOTE: Authority cited: Section 10270.94, Insurance Code. Reference: Sections 10350 and 10351, Insurance Code.

HISTORY

1. Amendment of Form A filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2232.18. Time Limit on Certain Defenses.

(a) After this policy has been in force for a period of three years, no statements of the employer contained in the application, and no statement relating to insurability made by any employee eligible for coverage under the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

(b) After three years from the date of issue of this policy, no misstatement of the employer, except a fraudulent misstatement, made in his application shall be used to void the policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability (as defined in the policy) commencing after expiration of such three years.

(c) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made:

Instructions

1. If the insurer uses Form A or Form B of the "Entire Contract; Changes" uniform provision, it may, at its option, include paragraph (a) in the policy (eliminating, if Form A is used, references to statements of employees), and the insurer shall use such paragraph, with the language appropriately adjusted, as aforesaid, in any policy which is noncancellable and guaranteed renewable for five years or more and for which the premium rate is guaranteed for five years or more. If said paragraph (a) is used, the insurer shall not use paragraph (b), and shall omit the portion of the first paragraph of Form C, if used, of the "Entire Contract; Changes" uniform provision following the phrase "unless it is contained in a written application."

2. In case the insurer uses Form A or Form C of the "Entire Contract; Changes" uniform provision, and unless paragraph (a) of this uniform provision is included in the policy in accordance with Instruction 1, the insurer shall include paragraph (b) therein, except that if the alternative language at the end of the first paragraph of Form C of the "Entire Contract; Changes" uniform provision is used and not omitted therefrom in accordance with Instruction 7 for the use of that form of such uniform provision, then the insurer may omit both paragraph (a) and (b) hereof. If Form A of the "Entire Contract; Changes" uniform provision is used, there shall be omitted from paragraph (a) or (b) hereof, whichever is used in the policy, all portions referring to statements of the employees.

3. The insurer shall omit paragraph (c) from any policy which does not exclude coverage for pre–existing diseases or conditions. The insurer shall use said paragraph (c) in any policy which contains any exclusion of pre–existing diseases or conditions. The term "pre–existing disease or conditions, means any diseases or conditions" means any disease or condition, other than pregnancy, of any employee or other person covered by the policy which existed on, or had its inception before the effective date of the insurance coverage of such person under the policy. (Ins. C. 10350.2 Cf. Ins. C. 10206 and 10270.6.)

§ 2232.19. Grace Period.

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the employer shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

Instructions

1. The termination of the group policy by the mutual consent of the parties, express or implied, terminates the entire contract, including the "Grace Period" uniform provision. Therefore, a provision in the policy, otherwise lawful, to the effect that the termination of the policy by the employer or by mutual consent, express or implied, of the employer and insurer, effective as of a premium due date or during a period of grace will terminate the period of grace for the payment of premiums as of the date of such termination of the policy is not inconsistent with this uniform provision.

2. The right of the insurer to cut off the grace period on five days' written notice, which is found in the corresponding individual uniform provi-

sion, is not applicable to group insurance, since five days is not sufficient time to replace a group policy, and this provision has been eliminated. Likewise, grace periods of shorter than 31 days are inappropriate to the peculiar group situation, and no provision for a shorter grace period has been permitted. Furthermore, it is inconsistent with the nature of group insurance to allow coverage during a grace period without requiring the payment of premiums accruing during such period. It follows that premiums on group policies containing the above grace period or its substance will continuously accrue until the policy is terminated, and the insurer, acting alone, cannot cut off the right of the employer to pay such accruing premiums on less than 31 days' notice. (Ins. C. 10350.3.)

§ 2232.20. Reinstatement.

There shall be no provision in a group disability policy relative to reinstatement of the policy after lapse because of default in the payment of premium nor shall there be any provision therein prior to the reinstatement relative to when the insurance coverage becomes effective again after such lapse and reinstatement. (Ins. C. 10350.4.)

§ 2232.21. Notice of Claim.

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at ____ or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer.

Instructions

1. In the blank space in this provision, the insurer shall insert the location of such office or offices as it may designate for the purpose of giving notice of claim.

2. The insurer may omit the second sentence of this provision if in the normal course of its business it makes all collections and services group disability accounts through its home office or branch offices and not through life and disability agents, and if it has conspicuously imprinted on the individual certificates (including supplemental certificates) the name of the insurer and the address of its home office and the address or addresses of the branch office or offices to which notice of claim and proof of loss may be sent. (Ins. C. 10350.5.)

§ 2232.22. Claims Forms.

The insurer, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. (Ins. C. 10350.6.)

§ 2232.23. Proofs of Loss.

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Instructions

In any policy which provides both benefits payable periodically and benefits payable when they occur or as they accrue, the insurer shall make clear by the terms of the policy which benefits are to be paid as they accrue or when they occur. This may be done in any lawful manner. Either of the two following ways would be acceptable. First, the insurer may specify in the benefit clauses themselves those benefits which will be paid periodically and those which will be paid as they accrue or when they occur, in which case no change in the language of the uniform provision is required. Second, the insurer may, in lieu of the phrase "in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss," identify by name or description or by place reference the benefits which will be paid periodically, and leaving unchanged the provision that as to any other loss proof is required within 90 days after the date of the loss. (Ins. C. 10350.7.)

§ 2232.24. Time of Payment of Claim.

Form A.

Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid (to the insured employee) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid (to the insured employee) and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Form B.

Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid (to the insured employee) as they accrue and any balance remaining unpaid at termination of the period of liability will be paid (to the insured employee) immediately upon receipt of due written proof.

Instructions

1. The insurer may use Form A or Form B at its option.

2. The insurer shall insert in the blank space in Form A a period for payment which shall not be less frequently than monthly.

3. If the insurer has chosen to specify ind identify in the uniform provision captioned "Proofs of Loss" the benefits for which proof of loss may be made within 90 days after termination of the period for which the insurer is liable, and if such insurer elects to use Form A, it shall in lieu of using the phrase "any loss other than loss for which this policy provides periodic payment" and "loss for which this policy provides periodic payment," specify and identify by name or description or by place reference the benefits for which no periodic payment is provided and benefits for which a periodic payment is provided.

4. The insurer shall omit the phrase in parentheses reading: "to the insured employee" if accidental death benefits are included in the policy, in which case the first paragraph of the uniform provision captioned "Payment of Claims" shall be used. (Ins. C. 10350.8.)

§ 2232.25. Payment of Claims.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured employee. Any other accrued indemnities unpaid at the insured employee's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured employee.

If any indemnity of this policy shall be payable to the estate of the insured employee, or to an insured employee or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay. such indemnity up to an amount not exceeding $____ to any relative by blood or connection by marriage of the insured employee or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured employee in an application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical service may, at the insurer's option, and unless the insured employee requests otherwise in writing not later than the time for filing proof of such loss, be paid

directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Instructions

1. The insurer shall use the first paragraph of this provision in any policy which provides a benefit for accidental death.

2. The insurer may omit the first paragraph if the policy does not include a benefit for accidental death and no provision is made for a beneficiary, in which case the phrase "to the insured employee" shall be used in the uniform provision captioned "Time of Payment of Claims."

3. The insurer may, at its option, use either or both of the second two paragraphs of this provision, or may omit them both, irrespective of whether the first paragraph is used or not.

4. If the insurer uses the second paragraph, there shall be inserted in the blank an amount not exceeding $1,000.

5. If the second paragraph is used and the policy makes no provision for the appointment of a beneficiary, the insurer shall omit from said second paragraph all references to payments to a beneficiary.

6. The insurer may substitute for the words "an application" in the second line of the third paragraph other words consistent with the policy terminology. (Ins. C. 10350.9)

§ 2232.26. Physical Examination and Autopsy.

The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Instructions

1. The clause relative to the right of the insurer to make an autopsy in case of death may be omitted from a policy which provides no benefit for accidental death.

2. The entire provision may be omitted from a policy which only provides one or more of the following benefits: hospitalization, medical expenses or surgical operations. (Ins. C. 10350.10.)

§ 2232.27. Legal Actions.

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. (Ins. C. 10350.11.)

§ 2232.28. Change of Beneficiary.

The right to change of beneficiary is reserved to the insured employee, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

Instructions

The insurer shall omit this provision from any policy which makes no provision for the designation of a beneficiary. (Ins. C. 10350.12.)

OPTIONAL UNIFORM PROVISIONS

§ 2232.30. Optional Uniform Provision Requirements.

No group disability policy subject to this article delivered or issued for delivery in this State shall contain provisions respecting any of the matters which are the subject of Sections 2232.31 to 2232.40, inclusive, unless such provisions are set forth in the policy in accordance with the requirements of such sections, and in the words, order and under the captions of the uniform provisions as set forth in Sections 2232.32, 2232.34, 2232.37, 2232.38, 2232.39, and 2232.40, subject, however, to the "General Instructions and Rules" of this article, provided, nevertheless, that the insurer may, at its option, subject to Section 2232.5 hereof, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner, which are in each instance not less favorable in any respect to the policyholder, any individual insured, or any beneficiary. Such provisions shall be preceded individually by the caption appearing herein as the caption for each such provision or by such other caption or subcaption as is herein specifically permitted, or, at the option of the insurer and subject to Section 2232.5 hereof, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

The Optional Uniform Provisions set forth in Article 5a, Chapter 4, Part 2, Division 2 of the Insurance Code for use in individual policies, which are captioned "Change of Occupation... Other Insurance in this Insurer," "Insurance With Other Insurers" as set forth in Section 10369.6 of the Insurance Code, "Relation of Earnings to Insurance" and "Unpaid Premiums" are not applicable to group disability insurance. Insofar as they are not applicable because the subject matter of such provisions are not consistent with group disability insurance, no provision incorporating such subject matter shall be set forth in any group disability policy. The instructions under the heading for each optional uniform provision state whether or not, or to what extent the subject matter of each such uniform provision as set forth in the Insurance Code for use in individual policies may be used in group disability policies. (Ins. C. 10369.1.)

§ 2232.31. Change of Occupation.

There shall be no provision in a group disability policy, other than provisions relative to eligibility or amounts or extent of coverage based on a plan precluding individual selection, reducing or prorating insurance because of change of occupation of the policyholder or any of the individuals covered under the policy. (Ins. C. 10369.2.)

§ 2232.32. Misstatement of Age.

Form A.

If the age of any individual covered under this policy has been misstated, the amount payable shall be such as the premium paid for the coverage of such individual would have purchased at the correct age.

Form B.

If the age of any individual covered under this policy has been misstated, there shall be an adjustment of the premium for this policy so that there shall be paid to the insurer the premium for the coverage of such individual at his correct age, and the amount of the insurance coverage shall not be affected.

Instructions

1. The insurer may not use either Form A or Form B unless the policy contains a schedule of premiums graded according to the age of all or some of the persons insured under the policy.

2. The insurer may, without regard to this uniform provision, include in a policy the premium for which is not determined by the ages of any of the individuals covered, provisions relating the amounts of insurance to the age of some or all of the individuals covered, and may provide that the true age of any such individual shall determine the amount of his insurance coverage.

3. Subject to the foregoing instructions, the insurer may, at its option, use either Form A or Form B as may be applicable. (Iris. C. 10369.3, Cf. Ins. C. 10208.)

§ 2232.33. Other Insurance in This Insurer.

(a) Except as provided in Section 2232.34 and as may elsewhere herein be otherwise provided, a provision in a group disability policy limiting or reducing the amount of coverage thereunder because of other coverage in the same insurer is not appropriate to or applicable for use in group disability policies and no such provision may be used therein.

(b) Except as provided in Section 2232.34 and as may elsewhere herein be otherwise provided, a provision in a group disability policy limiting coverage thereunder and under other disability policies issued by the same insurer to coverage under any one such policy is not appropriate to or applicable for use in group disability policies and may not be used therein. (Ins. C. 10369.4)

§ 2232.34. Insurance with Other Insurers.

Form A.

Reduced Hospital Benefits in Case of Coverage Under the California Unemployment Insurance Code. The hospital benefits otherwise payable

to insured employees hereunder shall be reduced by the amounts of additional benefits during hospital confinement to which such employees shall become entitled pursuant to the California Unemployment Insurance Code or any voluntary plan approved thereunder which is specifically identified in this policy or in the application therefor or in a rider attached to this policy specifically referring to this provision, as such plan is constituted on the effective date of this policy or such rider, as the case may be.

Instructions for Use of Form A

1. The insurer may use this provision only in a policy providing hospital benefits.

2. In lieu of incorporating this uniform provision in the policy, the insurer may, at its option, incorporate the substance or effect thereof, or a provision more favorable to insured employees, in the statement of hospital benefits of the policy by way of an affirmative statement of the benefits applicable to those employees who are also entitled to additional benefits during hospital confinement under the California Unemployment Insurance Code or an existing voluntary plan proved pursuant thereto, or applicable to a period of time for which such additional benefits are payable, or to both. Such affirmative statement of benefits may specifically eliminate or reduce hospital benefits because, or by the amount of the benefits on account of hospitalization to which the employee is entitled as state plan benefits under the California Unemployment Insurance Code to make such equitable adjustment of premium and premium rate for the policy as will after giving effect to the changes in the benefits of the policy resulting from the amendments of the California Unemployment Insurance Code, make such premium and premium rate thereafter commensurate with the premium and premium rate for the benefits theretofore provided by the policy.

Form B. Insurance With Other Insurers, Expense Incurred Basis.

If there be other valid coverage, not with this insurer, on any individual with respect to whom coverage is provided by this policy, providing benefits for the same loss on a provision of service basis or an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of the loss, then the only liability under an expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total like amount under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of each portion of the premium paid as shall exceed the prorated portion of the amount of benefits so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Instructions for Use of Form B

(1) The insurer may include Form B in any policy providing benefits upon an expense incurred basis. The insurer may, at its option, include in this provision a definition of "other valid coverage" approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or by hospital or medical service organizations, and to any other coverage, the inclusion of which may be approved by the commissioner. In the absence of such definition, such term shall not include individual insurance, automobile medical payment insurance or coverage provided by hospital or medical service organizations, or by union welfare plans or employer or employee benefit organizations. For the purpose of applying this provision with respect to any person with respect to whom insurance coverage is provided, any amount of benefit provided for such person pursuant to any compulsory benefit statute (including any workmen's compensation, or employers' liability statute) whether provided by a government agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying this provision no third party liability coverage shall be included as "other valid coverage." The insurer may restrict the applicability of this provision by the definition of "other valid coverage" to other group insurance benefits.

Instructions Applicable to Form A and Form B

Except as may be herein otherwise provided, the proration of benefits of a group disability policy because of other insurance covering the same loss is not appropriate to or applicable for use in group disability policies providing benefits other than benefits upon an expense incurred basis, except to the extent that Form A above is used in accordance with the instructions for its use, and no other such provision may be used. (Ins. C. 10369.5 and 10369.6.)

§ 2232.35. Policy Provisions Not Deemed to Be Proration.

(a) Notwithstanding the prohibitions of Sections 2232.33 and 2232.34, an insurer may include in the policy affirmative statements of coverage or affirmative provisions, otherwise lawful, relating to the conditions of eligibility or the conditions determining the amounts of insurance, which may refer to other insurance with the same or another insurer, if the amount of coverage of the policy and the individuals with respect to whom coverage is provided thereunder can be determined with particularity for each period of time for which premium is paid to the insurer, without having to take into consideration the probabilities of other insurance not yet in effect or not yet disclosed, but which may in the future become in effect or be disclosed, affecting the amounts of benefits payable.

(b) Group policies or contracts which are in force on January 1, 1975, and which contain either an "excess" or a "non–duplication" provision, other than as specifically provided in this section shall be brought into compliance with this section by the later of the next annual renewal date of such policies or contracts, or the expiration of a collectively bargained contract pursuant to which they were written.

NOTE: Authority cited: Section 10369.1, Insurance Code. Reference: Sections 10369.1– 10369.12, Insurance Code.

HISTORY

1. Amendment and new subsection (b) filed 11–29–74; designated effective January 1, 1975 (Register 74, No. 48).
2. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2232.36. Relation of Earnings to Insurance.

An insurer shall not include in any group disability policy any provision reducing or prorating benefits because of the earnings of the insured employee, other than as such earning may properly affect eligibility or amounts of coverage based on a plan precluding individual selection. (Ins. C. 10369.7.)

§ 2232.37. Unpaid Premiums.

An insurer shall not include in any group disability policy any provision for the deduction of any premium or any portion thereof from any claim upon its payment. (Ins. C. 10369.8.)

§ 2232.38. Cancellation.

The insurer may cancel this policy at any time by written notice delivered to the employer, or mailed to his last address as shown on the records of the insurer, stating when, not less than 31 days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the employer may cancel this policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either the insurer or the employer, the insurer shall promptly return on a prorata basis the unearned premium paid, if any, and the employer shall promptly pay on prorata basis the earned premium which has not been paid. (In computing the prorata premium to be returned by the insurer or to be paid by the insurer or to be paid by the employer, any discounts in premium or premium rate actually allowed to the employer because of the longer periods for which premiums, at the time of the cancellation, had been paid or agreed to be paid shall be disregarded, and the prorata return or payment of premium will be computed upon the basis

of the insurer's regular and customary premium or premium rate for the coverage of this policy.) Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Instructions

1. The insurer may, at its option, omit the phrase "after the policy has been continued beyond its original term" after the "and" following the first semicolon.

2. Any provision of the policy by which the insurer is given the right to terminate coverage or increase premiums affects rights under the policy substantially similar to cancellation, and any such provision which results in the insurer having the right to terminate coverage or increase premium on less than 31 days written notice delivered or mailed to the employer at his last address as it appears on the records of the insurer is less favorable than this uniform provision and is a violation of Section 2232.6 of this article. However, termination of the entire policy or increase of premium negotiated by the mutual agreement, express or implied, of the parties terminates the entire contract including the "Cancellation" uniform provision, or modifies a provision of the policy without reference to cancellation or threat thereof. Such results may in fact be so accomplished notwithstanding the provisions of the policy relating to cancellation by the unilateral acts of the insurer or the employer. A policy provision relating to termination at a premium due date by mutual consent, irrespective of notice, or whereby the insurer gives advance consent to such a termination by the employer is not inconsistent with this uniform provision. (Ins. C. 10369.9.)

3. The insurer may, at its option, include or omit the next to the last sentence enclosed in parentheses.

§ 2232.39. Conformity with State Statutes.

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute. (Ins.C. 10369.10.)

§ 2232.40. Illegal Occupation or Commission of Felony.

The insurer shall not be liable for any loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation. (Ins. C. 10969.11.)

§ 2232.41. Intoxicants and Narcotics.

The insurer shall not be liable for any loss sustained or contracted in consequence of the person whose injury or sickness is the basis of claim being intoxicated or under the influence of any narcotic unless administered on the advice of a physician. (Ins. C. 10369.12.)

Article 2.2. Limits on Benefit Reductions in Group Disability Income Insurance Policies

§ 2232.45.1. Authority and Purpose.

This article is promulgated pursuant to the authority granted to the Insurance Commissioner by section 790.10 of the Insurance Code. The purpose of this article is to set forth uniform standards which prohibit certain benefit reduction provisions in group disability income insurance policies. This article also clarifies an insurer's duty of good faith and fair dealing in estimating earnings received by the insured for work performed while disabled. This article applies to all insurers authorized to transact disability insurance in this State.

NOTE: Authority cited: Section 790.10, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, (1989) 48 Cal.3d 805; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 790.02 and 790.03, Insurance Code.

HISTORY

1. New article 2.2 (sections 2232.45.1–2232.45.5) and new section filed 6–24–2008; operative 8–23–2008 (Register 2008, No. 26).

§ 2232.45.2. Benefit Reductions Shall Not Be Based on Involuntary Retirement.

A policy of group disability income insurance which is subject to approval under the California Insurance Code shall not contain any provision that permits the insurer to estimate the amount of the following benefits the insured would receive if the insured retired, and deduct said estimated amounts from the benefits payable to the insured under the policy, when the insured has not voluntarily retired:

(a) Social security normal retirement age benefits;

(b) Public disability retirement benefits;

(c) Private disability retirement benefits;

(d) Public normal retirement age benefits;

(e) Private normal retirement age benefits.

Nothing in this section prohibits an insurer from deducting the amount of a benefit listed above, to the extent the benefit is deductible under existing law, when the benefit has been received by the insured as a result of the insured's voluntary retirement.

NOTE: Authority cited: Section 790.10, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, (1989) 48 Cal.3d 805; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 790.02 and 790.03, Insurance Code; *Kalvinskas v. California Institute of Technology* (9th Cir. 1996) 96 F.3d 1305; *Gruenberg v. Aetna Insurance Company* (1973) 9 Cal.3d 566; *Smith v. Alum Rock Union Elementary School District* (1992) 6 Cal. App.4th 1651.

HISTORY

1. New section filed 6–24–2008; operative 8–23–2008 (Register 2008, No. 26).

§ 2232.45.3. Benefit Reductions Shall Not Be Based on Estimated Workers' Compensation Temporary Disability Benefits Not Actually Received by the Insured.

A policy of group disability income insurance which is subject to approval under the California Insurance Code shall not contain any provision that permits the insurer to estimate the amount of workers' compensation temporary disability benefits the insured would receive, but has not actually received, and deduct said estimated amounts from the benefits payable to the insured under the policy.

NOTE: Authority cited: Section 790.10, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, (1989) 48 Cal.3d 805; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 790.02 and 790.03, Insurance Code; and *Silberg v. Cal. Life Ins. Co.* (1974) 11 Cal.3d 452.

HISTORY

1. New section filed 6–24–2008; operative 8–23–2008 (Register 2008, No. 26).

§ 2232.45.4. Benefit Reductions Shall Not Be Based on Workers' Compensation Permanent Disability.

A policy of group disability income insurance which is subject to approval under the California Insurance Code shall not contain any provision that permits the insurer to reduce benefits by deducting for workers' compensation permanent disability benefits.

NOTE: Authority cited: Section 790.10, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, (1989) 48 Cal.3d 805; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 790.02 and 790.03, Insurance Code; *Erreca v. Western States Life Insurance Co.* (1942) 19 Cal.2d 388; *Russell v. Bankers Life Co.* (1975) 46 Cal. App.3d 405; and *Canova v. N.L.R.B.* (1983) 708 F.2d 1498.

HISTORY

1. New section filed 6–24–2008; operative 8–23–2008 (Register 2008, No. 26).

§ 2232.45.5. Benefit Reductions Based on Earnings Received for Work Performed While Disabled.

An insurer has a duty of good faith and fair dealing, which includes a duty not to unreasonably withhold payments due under a policy. An insurer shall not estimate the earnings received by the certificate holder for work performed while the certificate holder is disabled, and deduct said estimated earnings from the benefit amount due to the certificate holder under a group disability income insurance policy, unless there is a good faith reasonable basis for the calculation of the amount of estimated earnings.

NOTE: Authority cited: Section 790.10, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, (1989) 48 Cal.3d 805; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 790.02 and 790.03, Insurance Code; and *Gruenberg v. Aetna Insurance Company* (1973) 9 Cal.3d 566.

HISTORY

1. New section filed 6–24–2008; operative 8–23–2008 (Register 2008, No. 26).

Article 2.3. Forms of Standard Provisions for Coordination of Benefits

§ 2232.50. Authority.

NOTE: Authority cited: Sections 10270.94 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. New Article 2.3 (Sections 2232.50 through 2232.60) filed 11–29–74; designated effective January 1, 1975 (Register 74, No. 48).
2. Repealer filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.51. Purpose.

HISTORY

1. Repealer filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.52. Applicability.

These regulations do not require the use of overinsurance provisions in group disability policies or group non–profit hospital service plan contracts. If, however, such a policy or contract contains overinsurance provisions, such provisions must be consistent with and no less favorable than the Standard Group Coordination of Benefit Provisions and Instructions herein established. To this end, overinsurance provisions, or provisions for the reduction of benefits otherwise payable because of other insurance by whatever name designated, which are less favorable than the Standard Coordination of Benefit Provisions herein contained may not be used, except that plans of coverage designated to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided. (See Section 2232.35 of Article 2a supra.)

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.53. Standard Provisions for Coordination of Benefits.

Every group disability policy which provides hospital, medical and surgical benefits issued in this state may contain the following standard provisions relating to Coordination of Benefits, as interpreted by the special instructions hereinafter set forth.

NOTE: Authority cited: Sections 10270.94,10270.98,11515 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.54. Benefits Subject to Coordination of Benefits Provision.

All of the benefits provided under this policy are subject to this provision.

Instructions

When the policy or nonprofit hospital service contract provides both integrated Major Medical Expense Benefits and the Basic Benefits, but the coordination of benefit provision applies to all or some of the benefits, use appropriate alternative wording such as illustrated below:

"Only the major medical expense benefits provided under this policy are subject to this provision."

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2)

§ 2232.55. Definitions.

(a) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

(1) group, blanket or franchise insurance coverage,

(2) service plan contracts, group practice, individual practice and other prepayment coverage,

(3) any coverage under labor–management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and

(4) any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(b) "This Plan" means that portion of this policy which provides the benefits that are subject to this provision.

(c) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(d) "Claim Determination Period" means a calendar year.

Instructions

The definition of a "Plan" within the COB provision of group contracts enumerates the types of coverage which the insurer may consider in determining whether overinsurance exists with respect to a specific claim. Such definition:

(a) May not include individual or family policies or individual or family subscriber contracts, except as otherwise provided in this special instruction.

(b) May include all group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to Section 10270.97 of the Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to Section 10270.2(b) or (e) which contain nonduplication of benefits or excess policy provisions.

(c) May not include to any extent whatever any entitlements to Medi–Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) or Part 3 of Division 9 of the Welfare and Institutions Code, or benefits under the California Crippled Children Services program under Section 10020 of the Welfare and Institutions Code or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non–governmental program.

(d) May not include the medical payment benefits customarily included in the traditional automobile contracts.

(e) May include "Medicare" or any other similar governmental benefits so long as it does not expand the definition of "Allowable Expenses" beyond the hospital, medical and surgical benefits as may be provided by the government program and so long as such benefits are not by law excess to this Plan.

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.56. Effect on Benefits.

(a) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the

Allowable Expenses incurred as to such person during such period, the sum of

(1) the benefits that would be payable under this Plan in the absence of this provision, and

(2) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(b) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (c) below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(c) If

(1) another Plan which is involved in paragraph (b) above and which contains a provision coordinating its benefits with those this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(2) the rules set forth in paragraph (d) below would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(d) For the purposes of paragraph (c) above, the rules establishing the order of benefit determination are:

(1) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent.

(2) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of benefits.

(3) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

(4) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(5) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding paragraphs (3) and (4) above, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(6) When rules (1) through (5) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

(A) the benefits of a plan covering the person on whose expenses claim is based as a laid–off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid–off or retired employee, or dependent of such person; and

(B) if either Plan does not have a provision regarding laid–off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (A) above shall not apply.

(e) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

Instructions

(a) When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved shall use the above rules to decide the order in the which the benefits payable under the respective plans will be determined.

(b) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, (e.g. single employer to multiple employer Plan, or vice versa, or single employer to a Taft–Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this instruction.

(c) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this instruction, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

(d) It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other overinsurance provisions not consistent with the provisions of these regulations. Such plans may have been written by certain self–insured or non–regulated entities not presently subject to insurance regulation, or by insurers or service corporations under policies or contracts issued prior to the effective date of these regulations, and which have not yet been brought into conformance with these regulations. In such cases, carriers are urged to use the following claims administration procedures: A group contract should pay first if it would be primary under the COB order of benefit determination. In those cases in which it would normally be considered secondary, the carrier should make every effort to coordinate in the secondary position with benefits available through such "excess" plans. The carrier should try to secure the necessary information from the "excess" plan.

(e) Provision (c) may be omitted if the plan provides only one benefit.

(f) A group contract which includes COB and which is issued or renewed, or which has an anniversary date on or after the effective date of this section as amended in 1986 shall include the substance of the provision in subsection (c) (2) of this section. That provision shall become effective, at the option of the insurer, on January 1, 1987, or one year after the effective date of this section as amended in 1986. Until that provision becomes effective, the group contract shall, instead, use wording like this:

"(2) Except as stated in paragraphs (3), (4) and (5), below, the benefits of a Plan which covers a person as a dependent of a male are determined before those of a Plan which covers the person as a dependent of a female."

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).
2. Editorial correction of printing error in subsection (d)(1) (Register 93, No. 32).

§ 2232.57. Right to Receive and Release Necessary Information.

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the insurer or service plan such information as may be necessary to implement this provision.

Instructions

Carriers are urged to use the following claims administration procedures to expedite claim payments where COB is involved:

(a) Each carrier should establish a time limit after which full or partial payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a COB provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment of benefits. Occasionally, this will necessitate a carrier making payment as the primary carrier with a right of recovery in the event that subsequent investigation proves that payment as a secondary carrier should have been made.

(b) There should be continued and improved education of claim personnel, stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP–1) Form by the inquiring carrier and the responding carrier. This education effort should also be encouraged through local claim associations. Claim personnel should be encouraged to make every effort to speed up exchange of COB information.

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 791.06, 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.58. Facility of Payment.

(a) Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer or service plan shall be fully discharged from liability under this plan.

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 10270–98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.59. Right of Recovery.

Whenever payments have been made by the insurer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer or service plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following; as the insurer or service plan shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

NOTE: Authority cited: Sections 10270.94, 10270.98, 11515 and 11515.5, Insurance Code. Reference: Sections 10270.98 and 11515.5, Insurance Code.

HISTORY

1. Amendment filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

§ 2232.60. Effective Date.

HISTORY

1. Repealer filed 1–8–86; effective thirtieth day thereafter (Register 86, No. 2).

Article 3. Small Employer Health Insurance

§ 2233. Definitions.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700–10711 and 10713–10717, Insurance Code.

HISTORY

1. New article 3 (sections 2233–2233.99) filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 77, No. 19.
2. Editorial correction amending article heading (Register 93, No. 44).
3. New section refiled 10–28–93 as an emergency with amendments; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
4. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
5. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
7. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.10. Applicability of Articles 1 and 2.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10202.8, 10270.5(a)(1), 10270.507, 10700(b), 10700(d), 10700(j), 10700(w), 10702, 10703 and 10705(a), Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, including amendments to subsections (a), (b)(1), newly designated subsection (f) and NOTE, new subsections (c)(1) and (c)(2) and subsection relettering, and repealer of subsection (g); operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.20. Renewal Date.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10713, 10714, 10716 and 10717, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.22. Termination.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700(w) and 10711(e), Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, including amendments to section heading, section and NOTE; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.40. Rates for Medicare–eligible Persons.

NOTE: Reference: Sections 10700(w)(1), 10714, 10715 and 10717, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Repealer filed 10–28–93 as an emergency; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).

§ 2233.50. Employees and Dependents Not Previously Covered.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700(*l*), 10707 and 10709, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, including amendments to section and NOTE; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.60. Filing of Association Disclosure Statements.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10705(b)(3) and 10705(b)(4), Insurance Code.

HISTORY

1. New section filed 10–28–93 as an emergency; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
2. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
3. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.70. Stop Loss Products.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10270.5(a)(1), 10290, 10291, 10700(b), 10700(d), 10700(j), 110700(r), 10708 and 10709, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, including amendment of NOTE; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.80. Participation Requirements.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700(b), 10700(d), 10700(f), 10702, 10705(b) and 10706, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, including amendment of subsection (b) and NOTE; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section

10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.82. Satisfaction of Participation Requirements.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700(e), 10700(k), 10700(x), 10702 and 10706, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Repealer filed 10–28–93 as an emergency; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).

§ 2233.90. PPOs and EPOs.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10133(b) through (e), 10700(b) and 10705(b)through (e) and (g), Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, including amendment of subsections (a) and (b), new subsection (g) and amendment of NOTE; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.98. Effective Date.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700–10711 and 10713–10717, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency, with amendments; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 with amendments as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

§ 2233.99. Severability.

NOTE: Authority cited: Section 10704, Insurance Code. Reference: Sections 10700–10711 and 10713–10717, Insurance Code.

HISTORY

1. New section filed 6–28–93; operative 7–1–93 (Register 93, No. 27). This regulatory filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–93 as an emergency; operative 10–29–93 (Register 93, No. 44). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 2–28–94 or emergency language will be repealed by operation of law on the following day.
3. Expired by operation of Government Code section 11346.1(e) (Register 94, No. 17).
4. New section filed as an emergency 4–28–94; operative 5–1–94 (Register 94, No. 17). This filing was deemed an emergency by Insurance Code section 10704. A Certificate of Compliance must be transmitted to OAL by 8–29–94 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 9–7–94 as an emergency; operative 9–6–94 (Register 94, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–4–95 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 12).

Article 4. Blanket Disability and Tuition Refund Policies

§ 2236. Forms to Which This Article Is Applicable.

This Article comprises the Rules and Regulations of the Insurance Commissioner relating to the substance, form and issuance of tuition refund policies described in Section 10270.1 of the Insurance Code and those blanket disability policies described in Section 10270.2 of the Insurance Code except policies issued to pay benefits afforded by a voluntary plan of employment compensation disability insurance pursuant to the California Unemployment Insurance Code. The term "blanket disability policy" as used herein, unless that context otherwise requires, refers to the policies to which this Article applies, including tuition refunds policies described in Section 10270.1 of the Insurance Code. No blanket disability policy affected by this Article may be delivered or issued for delivery in this State which does not, in substance and in the method of its issuance, meet all of the applicable provisions and requirements of Section 10270.1 of the Insurance Code or Section 10270.2 of the Insurance Code, as applicable, whether or not such form has heretofore been authorized or approved by the Commissioner. The Commissioner shall not hereafter approve any such policy unless it conforms with the rules set forth in this Article, and no such form shall be issued hereafter except in conformity with the rules set forth in the Article.

NOTE: Authority cited for Article 4: Sections 10270.1 and 10270.2, Insurance Code.

HISTORY

1. Repealer of Article 4 (2236 and 2237) and new Article 4 (2236 through 2236.5) filed 4–4–56; effective thirtieth day thereafter (Register 56, No. 6).
2. Repealer of Article 4 (2236 through 2236.5) and new Article 4 (2236 through 2236.7) filed 4–27–70; designated effective 7–1–70 (Register 70, No. 18).

§ 2236.1. Certificates or Other Forms of Statements of Coverage.

No certificate or other form of statement of coverage need be issued under a blanket disability policy, unless the policy itself provides for the issuance of certificates or some other form of statement of coverage; in which case, certificate forms or some other form of statement of coverage adequately describing the coverage, the person covered, and the persons to whom benefits are payable must be submitted for authorization, and upon authorization must be issued in accordance with the policy provisions. Such certificates or other statements of coverage are not required to be individualized.

§ 2236.2. Addition of New Persons Eligible.

In the absence of a policy provision excluding coverage for otherwise covered individuals who have not individually enrolled with the policy-

holder and undertaken to pay all or a specified portion of the premium applicable to such individual, a blanket disability policy (but not a tuition refund policy) shall contain, in substance, a provision which provides that the described insurance covers all persons who fall within the categories of covered individuals defined in the policy, and that to the persons originally insured by the policy shall be added automatically all such persons as they come within the class of persons defined in the policy issued to the master policyholder.

§ 2236.3. Provisions Required.

(a) The Uniform Provisions for group disability insurance and the Instructions for their use, and the definition of words set forth in Sections 2232.1 to 2232.41, inclusive, of Article 2a of Title 10, insofar as applicable, shall be required and shall apply to disability policies; except that insofar as applicable to blanket disability policies such Uniform Provisions and Instructions for their use are hereby amended in the following respects:

(1) In a tuition refund policy in place of using the Uniform Provision captioned "Payment of Claims" the insurer may use one of the following provisions:

Form A. Payment of Claims

All benefits provided in this policy will be paid to the school hereby insured immediately after receipt of due proof of loss in repayment for the return of, or in payment of, tuition, fees, or charges of the school for the period of attendance of the pupil lost by reason of disability covered by this policy.

Form B. Payment of Claims.

All benefits provided in this policy will be paid immediately after receipt of due proof of loss, to the person paying tuition charges for the pupil suffering disability covered by this policy.

(2) In blanket disability policies issued to provide accidental death benefits, the insurer, in place of using the first paragraph of the Uniform Provision captioned "Payment of Claims," may use the following provisions, in which case no provision may be included in the policy whereby the individual insured may appoint a beneficiary:

Payment of Claims.

Indemnity for loss of life of a minor insured will be payable to his parents or guardians, if surviving the insured, otherwise to the estate of the insured. Indemnity for loss of life of any other insured will be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the parents guardians or estate of the insured. All other indemnities, will be payable to insured.

The instructions for the use of said Uniform Provision in group disability policies are also applicable to the above form. In such blanket disability policies, the insurer shall omit the Uniform Provision captioned "Change of Beneficiary" if the last above form of alternative Uniform Provision captioned "Payment of Claims" is used.

(3) (i) In blanket disability policies issued to provide hospital, medical or surgical benefits resulting from accidents or sickness, in lieu of the first paragraph of the Uniform Provision captioned "Payment of Claims," the insurer may the following paragraph:

All indemnities of this policy shall be payable to the insured and any accrued indemnities unpaid at the death of the insured (*) may be paid to the estate of the deceased (*).

(3) (ii) In lieu of the second and third paragraphs of said Uniform Provision captioned "Payment of Claims," the insurer may use the following paragraphs: If any indemnity of this policy shall be payable to the estate of any insured (*), or to an insured (*) who is a minor or in the judgment of the insurer otherwise not competent to give valid release, the insurer may pay such indemnity to the person responsible for the insured's (**) support. Any payments made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

All or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, and unless a person to whom benefits might otherwise be payable thereunder requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the services be rendered by a particular hospital or person.

*Insurer shall insert the proper word or words to describe the individual or individuals insured.

**Insurer shall insert in blank space the proper word or words to describe the individual or individuals insured.

§ 2236.4. Insurance Code Sections Applicable.

Section 10191, 10270.3, subdivisions (a) and (d) of Section 10270.6, subdivision (b) of Section 10290, Section 10291, paragraph (1) of subdivision (b) of Section 10291.5, subdivisions (a), (b), (d), (e), (f), (g) and (h) of Section 10320, and Sections 10321, 10322, 10326, 10326.5, 10380, 10381, and 10382 of the Insurance Code shall apply to blanket disability policies and reference in such sections to the insured shall, in applying

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such sections to blanket disability policies, be deemed to refer also to the individuals insured under such policies.

NOTE: Authority cited: Sections 10270.1 and 10270.2, Insurance Code. Reference: Sections 10270.2 and 10270.3, Insurance Code.

HISTORY

1. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2236.5. "Employee" Includes.

Whenever the word "employee" is used in Article 2a of Subchapter 2 of Chapter 5 of Title 10, there may be substituted therefor the word "camper," "participant," "member," "subscriber," "student," or "teacher," or any other word or words to properly describe or designate the individual or individuals eligible for insurance under Sections 10270.1 and 10270.2 of the Insurance Code.

§ 2236.6. "Employer" or "Policyholder" Includes.

Whenever the word "employer" or the word "policyholder" is used in Article 2a of Subchapter 2 of Chapter 5 of Title 10, it includes any organization, entity or person to whom the policy may be issued under Sections 10270.1 or 10270.2 of the Insurance Code. Whenever the word "employer" or the word "policyholder" is used in any Uniform Provision in said Article 2a of Title 10, there may be substituted therefor any word or words which properly describe or designate any of the entities enumerated in subdivisions (a), (b), (c), (d), (e), or (f) Section 10270.2.

§ 2236.7. Use of Rider.

Changes in the forms of blanket disability policies submitted to the Commissioner for approval which are necessary to bring them into compliance with the rules and provisions hereby promulgated may be effected by rider.

Article 4.5. Group Disability Income Policies Insuring Employees of California School Districts

§ 2237. Preamble.

Certain group disability income policies providing indemnity for loss–of–time to employees of California school districts contain provisions permitting a reduction in benefit otherwise payable by an amount equal to all or part of the benefits the insured employee receives or is entitled to receive under any other policy of group income insurance. In some cases, an employee of a school district is insured under two, or possibly more, such group disability income policies, each or all of which contain a reduction of benefits provision. Such a situation has caused delays in benefit payment and could conceivably result in the school district employee receiving no benefit payment. This action would constitute an unfair claim settlement practice within the meaning of Insurance Code Section 790.03 (h).

NOTE: Authority cited: Sections 790.10 and 10270.94, Insurance Code.

HISTORY

1. New Article 4.5 (Sections 2237–2237.4) filed 3–29–74 as an emergency; effective upon filing (Register 74, No. 13).
2. Certificate of Compliance filed 6–20–74 (Register 74, No. 25).

§ 2237.1. Authority.

This regulation promulgated under the authority of Insurance Code Sections 790.10 and 10270.94.

§ 2237.2. Definitions.

As used in this regulation:

(a) "Group disability income policy" means a group insurance policy providing indemnity for loss–of–time issued or issued for delivery in this State pursuant to the provisions of Insurance Code Section 10270.5 under which eligibility for coverage is restricted substantially to employees of California school districts, whether insured as members of an association or as employees of a school district, and which contains a reduction of benefits provision.

(b) "Reduction of benefits provision" means a provision in a group disability income policy permitting the insurer to reduce the disability income benefit payable thereunder by an amount equal to all or part of the benefits the insured receives or is entitled to receive under any other group disability income policy.

(c) "Duplicating insurance" means the coverage of the same California school district employee under two or more group disability income policies.

(d) "Net benefit" means the amount of benefit payable under a group disability income policy prior to the application of a reduction of benefits provision, but after deducting all other items to be subtracted to determine benefits as provided in the group disability income policy (e.g., Social Security payments, workmen's compensation, etc.).

(e) "Maximum net benefit" means in the case of duplicating insurance the higher or highest net benefit payable under any of the group disability income policies under which the employee is entitled to receive benefits.

§ 2237.3. Standards for Reduction of Benefits Provisions.

The reduction in benefits provision in each group disability income policy issued, issued for delivery or renewed in this State after the effective date of this regulation shall provide in substance that in the case of duplicating insurance the liability of the insurer under its group disability income policy shall not be less than its pro rata share of the maximum net benefit, which pro rata share shall be determined by dividing the net benefit payable by the insurer under its group disability income policy by the total of all net benefits under all group disability income policies under which the insured is entitled to receive benefits and multiplying that result by the maximum net benefit.

No reduction of benefits provision in a group disability income policy not containing the standards described in this section or standards not less favorable to the insured shall be approved by the Commissioner. The reduction of benefits provision in each group disability income policy heretofore issued in this State, which is renewed after the effective date of this regulation, shall be amended to contain the standards described in this section or standards not less favorable to the insured.

§ 2237.4. Exchange of Information.

Where a determination of the net benefit payable by another insurer providing duplicating insurance is required by an insurer, at the insurer's request, such other insurer shall furnish all necessary and pertinent information concerning its net benefit sufficient to permit verification of benefit determination by the insurer.

Article 5. Facility of Payment Clauses

NOTE: Authority cited: Section 10369, Insurance Code. Reference: Sections 10359–10369, Insurance Code.

HISTORY

1. Repealer of Article 5 (Section 2238) filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19). For prior history, see Register 3 and Register 10, No. 5.

Article 6. Provider Network Access Standards for Disability Policies and Agreements

§ 2240. Definitions.

As used in this Article:

(a) "Basic health care services" means any of the following covered health care services provided for in the applicable insurance contract or certificate of coverage:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance services.

(7) Mental health care services including those intended to meet the requirements of Insurance Code 10144.5.

(8) Any other health care or supportive services that are covered pursuant to an insurance contract.

(b) "Certificate" means an individual or family certificate of coverage issued pursuant to an insurance contract.

(c) "Covered person" means either a primary covered person or a dependent covered person eligible to receive basic health care services under the insurance contract providing network provider services.

(d) "Dependent covered person" means someone who is eligible for coverage under an insurance contract through his or her relationship with or dependency upon a primary covered person.

(e) "Emergency health care services" means health care services rendered for any condition in which the covered person is in danger of loss of life or serious injury or illness or is experiencing severe pain and suffering.

(f) "Network provider" means an institution or a health care professional which renders health care services to covered persons pursuant to a contract to provide such services at alternative rates.

(g) "Network provider services" means health care services which are covered under an insurance contract when rendered by a network provider within the service area.

(h) "Non–network provider services" means covered health care services delivered by a health care provider who is not contracted with the insurer either directly or indirectly.

(i) "Health care professional" means a licensee or certificate holder enumerated in Insurance Code 10176 as of the effective date of this Article or as that Section may be amended thereafter.

(j) "Insurer" means an insurer who provides 'health insurance" as defined in Section 106(b), and includes those who authorize insureds to select providers who have contracted with the insurer for alternative rates of payment as described in Section 10133.

(k) "Primary care physician" means a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board–certified or board–eligible internist, pediatrician, obstetrician–gynecologist or family practitioner.

(*l*) "Primary covered person" means a person eligible for coverage under an insurance contract or certificate.

(m) "Service area" means the State of California or any other geographic area within the state designated in the contract within which network provider services are rendered to covered persons for covered benefits.

(n) "Network" means all institutions or health care professionals that are utilized to provide medical services to covered persons pursuant to a contract with an insurer to provide such services at alternative rates as described in Insurance Code Section 10133. A network as defined herein can be directly contracted with by an insurer or leased by an insurer.

NOTE: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133, 10133.5, 10144.5 and 10176, Insurance Code.

HISTORY

1. New Article 6 (Sections 2240, 2240.1–2240.4) filed 1–24–84; effective thirtieth day thereafter (Register 84, No. 4). For history of former Article 6, see Register 77, No. 19.
2. Amendment of article heading, section and NOTE filed 1–8–2008; operative 2–7–2008 (Register 2008, No. 2).

§ 2240.1. Adequacy and Accessibility of Provider Services.

(a) The provisions of this article apply to "health insurance" policies as defined by Insurance Code section 106(b). Notwithstanding the above, the provisions of this article do not apply to supplemental policies of health insurance that provide coverage for vision care expenses only or dental care expenses only.

(b) In arranging for network provider services, insurers shall ensure that:

(1) Network providers are duly licensed or accredited and that they are sufficient, in number or size, to be capable of furnishing the health care services covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services.

(2) Decisions pertaining to health care services to be rendered by providers to covered persons are based on such persons' medical needs and are made by or under the supervision of licensed and appropriate health care professionals.

(3) Facilities used by providers to render basic health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible to the physically handicapped.

(4) Basic health care services (excluding emergency health care services) are available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.

(5) Emergency health care services are available and accessible within the service area at all times.

(6) Basic health care services are accessible to covered persons through network providers, or other network arrangement.

(7) Network provider services are rendered pursuant to written procedures which include a documented system for monitoring and evaluating accessibility of such care. The monitoring of waiting time for appointments shall be a part of such a system.

(c) In arranging for network provider services, insurers shall ensure that:

(1) There is the equivalent of at least one full–time physician per 1,200 covered persons and at least the equivalent of one full–time primary care physician per 2,000 covered persons.

(2) There are primary care network providers with sufficient capacity to accept covered persons within 30 minutes or 15 miles of each covered person's residence or workplace.

(3) There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace. Notwithstanding the above, the Commissioner may determine that certain medical needs require network specialty care located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code 10133.5(b) (3), support such modification.

(4) There are mental health professionals with skills appropriate to care for the mental health needs of covered persons and with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace.

(5) There is a network hospital with sufficient capacity to accept covered persons for covered services within 30 minutes or 15 miles of a covered person's residence or workplace.

(6) Notwithstanding the above, these requirements are not intended to prevent the covered person from selecting providers as allowed by their insurance contract beyond the applicable geographic area specified by these standards.

(7) If an insurer is unable to meet the network access standard(s) required by this section due to the absence of practicing providers located within sufficient geographic proximity of the insurer's covered persons, the insurer may apply to the Commissioner for a discretionary waiver of any network access standard for the applicable geographic area. Such application should include, at a minimum, a description of the affected area and covered persons in that area and how the insurer determined the absence of practicing providers.

(d) In determining whether an insurer's arrangements for network provider services comply with these regulations, the Commissioner shall

consider to the extent the Commission deems necessary, the practices of comparable health care service plans licensed under the Knox–Keene Health Care Service Plan Act of 1975 Health and Safety Code Section 1340, et seq.

NOTE: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133 and 10133.5, Insurance Code.

HISTORY

1. Amendment of section heading, section and NOTE filed 1–8–2008; operative 2–7–2008 (Register 2008, No. 2).

§ 2240.2. Insurance Contract Provisions.

Insurance contracts containing provisions covering network provider services shall contain the following:

(a) A provision for coverage on an indemnity or provision of service basis for emergency health care services rendered to covered persons outside the service area.

(b) A provision that the insurer shall give written notice to the group contract holder, within a reasonable period of time, of any termination or permanent breach of contract by, or permanent inability to perform of, any network provider if such termination, breach or inability would materially and adversely affect the contract holder or covered persons.

(c) A provision that the contract holder shall distribute to the primary covered persons the substance of any notice given to the contract holder pursuant to subsection (b) not later than 30 days after its receipt.

(d) A provision that, pursuant to Insurance Code Section 10133.56, upon termination of a network provider contract, the insurer shall be liable for covered services rendered by such provider to a covered person under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. This provision need not provide that the insurer shall be liable for any services rendered to a covered person after such person ceases to be eligible for coverage under the insurance contract.

(e) A provision defining the service area.

NOTE: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5 and 10133.56, Insurance Code.

HISTORY

1. Amendment of section heading, section and NOTE filed 1–8–2008; operative 2–7–2008 (Register 2008, No. 2).

§ 2240.3. Provisions of Certificates.

Certificates containing provisions covering network provider services shall contain the following:

(a) A description of the coverage provided by the contract for emergency health care services rendered to covered persons outside the service area.

(b) A description of the coverage, if any, provided by the contract for dependent covered persons who both live outside the service area and away from the principal residence of the primary covered person.

(c) A brief and prominent warning reflecting the limitations in the contract pertaining to network provider services. Such warning shall identify, by caption or number, the certificate provisions required by subsections (d), (e) and (f), below.

(1) Where the contract provides coverage outside the service area, the warning shall be in bold–face type or set off by other means from the surrounding text, and shall clearly specify the differences in coverage between network and non–network services in and out of the service area.

(2) Where the contract provides no coverage (except for emergency health care services) outside the service area, the warning shall include the warning required in (1) above, and shall additionally warn that no coverage is provided outside the service area, except for emergency health care services. The additional warning shall be in a point size at least twice that used in the body of the certificate (excluding captions).

(d) If applicable, a provision defining the service area wherein coverage is restricted to services provided by network providers.

(e) A provision or attachment identifying all network providers or describing where a current directory of network providers can be found on the Internet.

(f) A prominent disclosure pursuant to Insurance Code Section 510 stating that covered persons who have complaints regarding their ability to access needed health care in a timely manner may complain to the insurer and to the California Department of Insurance. The disclosure shall include the address and the customer services telephone number of the insurer and the name address and toll free telephone number of the Consumer Services Division of the Department of Insurance

NOTE: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 510, 10133 and 10133.5, Insurance Code.

HISTORY

1. Amendment of section and NOTE filed 1–8–2008; operative 2–7–2008 (Register 2008, No. 2).

§ 2240.4. Contracts with Exclusive Providers.

(a) Effective June 30, 2008, contracts between network providers and insurers or their agents shall: 1) be in writing and be fair and reasonable as to the parties to such contracts; 2) provide that network providers shall not make any additional charges for rendering network services except as provided for in the contract between the insurer and the insured; 3) include all the agreements between the parties pertaining to the rendering of network provider services; 4) recite that the provider's primary consideration shall be the quality of the health care services rendered to covered persons; 5) include provisions ensuring that providers shall not discriminate against any insured in the provision of contracted services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage , utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider.

NOTE: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

HISTORY

1. Amendment of section and NOTE filed 1–8–2008; operative 2–7–2008 (Register 2008, No. 2).

§ 2240.5. Filing and Reporting Requirements.

(a) Whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver basic health care services, the insurer shall at the same time file with the Policy Approval Bureau of the California Department of Insurance:

(1) A report describing the number and location of all network providers utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations, such as a report produced using GeoAccess GeoNetworks® software offered by Ingenix Corporation.

(2) An affidavit or attestation acknowledging compliance with all the requirements of this regulation.

(3) A copy of written procedures required by Section 2240.1 (b)(7).

(4) Complete copies, including all appendices, attachments and exhibits, of the most commonly utilized network provider contracts for each type of provider the insurer (or its agent if using a leased network) includes in the provider network, including but not limited to hospital, individual physician, group physician, laboratory, mental health rehabilitation and ancillary service contracts. Rates or rate schedules need not be provided with this filing. All material changes to provider contracts must be filed with the Policy Approval Bureau as they become effective.

(b) Any insurer who by June 30, 2008 has not filed all of the information required by subsection (a) (1), (2), (3), and (4) pertaining to each network of providers used for delivery of medical services under any policy of insurance in force, sold or offered for delivery in California shall do so for each such network by that date.

(c) An insurer seeking approval for a new product which will utilize a network that has previously been described to or filed with the department pursuant to subsections (a)(1) or (b), may file an affidavit or attestation stating that the network to be utilized for the new product is substantially the same as one previously filed, and that there have been no material changes to the network that would result in failure to comply

with any of the provisions of this article. Such affidavit shall clearly identify the previous filing, and shall, if appropriate, recalculate the ratios required by Section 2240.1(c)(1) taking into account projected new covered lives.

(d) An insurer must notify the department immediately at any time that a material change to any of its networks results in the insurer being out of compliance with any of the provisions of these regulations and, at the same time, submit a corrective plan specifying all actions that the insurer is taking, or will take, to come into compliance with these provisions, and estimating the time required to do so.

(e) Health insurers that contract for alternative rates of payment with providers shall report annually to the Consumer Services Division of the Department of Insurance on complaints received by the insurer regarding timely access to care. This report shall include a summary of receipt and resolution of complaints regarding access to or availability of any of the following services by type of service: primary care services, specialty care services, mental health professional services and hospital services.

(f) The department shall review these complaint reports and any complaints received by the department regarding timely access to care and shall make this information public.

NOTE: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

HISTORY

1. New section filed 1–8–2008; operative 2–7–2008 (Register 2008, No. 2).

Article 6.5. Unemployment Compensation Disability Policies

SCOPE OF ARTICLE AND DEFINITIONS

§ 2241. Policies Subject to Article.

The rules and regulations contained in this article are promulgated pursuant to Section 10270.2 of the Insurance Code to apply to policies and forms providing the unemployment compensation disability benefits under voluntary plans of unemployment compensation disability insurance pursuant to Part 2, Division 1 of the California Unemployment Insurance Code. If any disability insurance other than the unemployment compensation disability benefits under the voluntary plan and other than additional benefits for loss of time is provided by the policy or any rider attached thereto, such policy or rider is governed, as respects such disability insurance, by the laws and rules and regulations applicable to such other disability policies.

Every policy issued by any insurer to provide Unemployment Compensation Disability benefits shall be issued only in conformity with this Article and the applicable laws of this State.

NOTE: Authority cited: Section 10270.2, Insurance Code. Reference: Section 10270.2 (f), Insurance Code.

HISTORY

1. New Article 6.5 (§§2241 to 2246) filed 12–1–47 (Register 10, No. 5).
2. Amended Article 6.5 (§§2241 through 2246) filed 4–4–56; effective thirtieth day thereafter (Register 56, No. 6).
3. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2241.1. Terms and Abbreviations Defined.

Unless the context otherwise requires, when used in this article the following words or abbreviations mean or include:

(a) "C. U. I. Code" means California Unemployment Insurance Code.

(b) "U. C. D." means California unemployment compensation disability as the words are used in the C. U. I. Code.

(c) "Voluntary plan" means a voluntary plan of U. C. D. benefits pursuant to Part 2, Division 1 of the C. U. I . Code.

(d) "Insurer" means an insurer admitted to transact disability insurance in California.

(e) "Director" means the Director of the Department of Employment Development.

(f) "Commissioner" means the Insurance Commissioner.

(g) "Employer" includes any entity or entities to which a U. C. D. policy may be issued.

(h) "Employee" includes all individuals, however named, who may be covered by a U. C. D. Policy.

(i) "Policy" includes any rider or endorsement effecting or affecting U. C. D. benefits.

NOTE: Authority cited: Sections 10270.2 and 10270.2(f), Insurance Code.

HISTORY

1. Amendment of subsection (e) filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

FILING AND APPROVAL

§ 2241.3. Filing and Approval Required.

No U. C. D. policy shall be issued or delivered by any insurer until:

(a) A copy of the form thereof is filed with the commissioner

(b) Either

(1) Thirty days expires without notice from the commissioner after such copy is filed, or

(2) The commissioner gives his written approval thereof prior to that time.

§ 2241.5. Filing Procedure.

U. C. D. policies and forms shall be submitted to the commissioner for filing with and approval by him in conformity with the requirements of Article 1 of this subchapter applicable to other disability policies and forms, except that in the submission of final copies for approval, each form shall be submitted in triplicate. In addition, one copy should be submitted to the Department of Employment Development, Division of Disability and Hospital Benefits, Sacramento, California.

NOTE: Authority cited: Section 10270.2, Insurance Code. Reference: Section 10270.2 (f), Insurance Code.

HISTORY

1. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2241.7. Notice of Disapproval; Contents: Withdrawal of Approval; Effect.

If the commissioner notifies an insurer, in writing, that a U. C. D. form filed by it does not comply with the requirements of law or this article, or both, specifying the respects in which it does not so comply, such insurer shall not issue any U. C. D. policy in such form. If, after having approved a U. C. D. form, the commissioner subsequently withdraws his approval pursuant to Section 12957 of the Insurance Code, such insurer shall not thereafter issue any U. C. D. policy in such form.

§ 2241.9. Policies Containing Misleading Provisions.

No U. C. D. policy or form will be approved by the commissioner for issuance or delivery if he finds that it contains any provision or has any title, heading, backing or other indication of its provisions which is likely to mislead a person to whom the policy is offered, delivered or issued or any employee insured or proposed to be insured thereunder.

§ 2242. Individual Certificates; Forms to Be Filed and Approved.

If individual certificates setting forth a statement as to the insurance whom payable are to be issued to the employees insured, the form thereof must first be filed with and approved by the commissioner in the manner provided in this article for filing and approval of policies.

§ 2242.1. Policies Not Conforming to C. U. I. Code or Regulations of Director.

Any U. C. D. policy or certificate which is found by the director not to conform to the requirements of the C. U. I. Code or the regulations of the director for voluntary plans, or both, will not be approved by the commissioner or, if previously approved by him, approval thereof will be withdrawn.

§ 2242.3. Policies to State Effective and Termination Dates: Size of Type Required.

No U. C. D. policy shall be issued or delivered by any insurer:

(a) Unless the times at which the insurance takes effect and terminates are clearly stated in the policy.

(b) Unless the policy be plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than 10–point with a lower–case unspaced alphabet length not less than 120 points.

§ 2242.5. Incorporated Provisions to Be Set Forth in Policies.

No U. C. D. policy shall be issued or delivered by any insurer if it contains any provisions purporting to make any portion of the charter, constitution or by–laws of the insurer a part of the policy unless such portion is set forth in full in the policy.

§ 2242.7. Provisions Contradictory to Required or Optional Provisions.

No U. C. D. policy shall be issued or delivered by any insurer which contains any provision contradictory, in whole or in part, of any of the required provisions or optional provisions hereinafter set forth or described or which conflicts with such required and optional provisions.

§ 2242.9. Foreign Insurers: What Provisions Required by State of Organization May Be Included.

U. C. D. policies issued by a foreign insurer (an insurer not organized under the laws of California) may contain any provision which is required by the law of the state or country under whose laws the insurer is organized if such provision is not inconsistent with the C. U. I. Code and the regulations of the director, and is not less favorable to the employer or any employee than the provisions of this article.

§ 2243. Policies Issued Out–of–State: What Provisions May Be Included.

U. C. D. policies issued outside this State may contain any provision required by the laws of the state or country where issued if such provision is not inconsistent with the C. U. I. Code and the regulations of the director.

§ 2243.1. In Lieu of Compliance Insurer May Comply with Article 2 Until January 1, 1957.

NOTE: Authority cited: Section 10270.2, Insurance Code. Reference: Section 10270.2 (f), Insurance Code.

HISTORY

1. Repealer filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2243.3. Substitutions Permitted in Required or Optional Provisions.

In respect to the forms for any of the required or optional provisions hereinafter set forth,

(a) Wherever the word "insurer" is used there may be substituted therefor "company," "corporation," "association," "society," or such other word as may properly designate the insurer.

(b) Wherever the word "employee" is used there may be substituted therefor "member" or other proper designation of the individual insured.

(c) Wherever the word "policy" is used there may be substituted therefor "rider," "endorsement," "contract," or other proper designation of the document embodying the contract between the parties to which the provision refers.

(d) Wherever the word "employer" is used, there may be substituted therefor "executive officer," "trustee," or other proper designation of the person maintaining application for a U.C.D. policy on behalf of an entity to whom such policy may lawfully be issued.

(e) Blanks shall be completed with appropriate material in conformity with any special instructions relative to matter to be inserted therein.

(f) Words or phrases in parentheses may be included or omitted at the option of the insurer.

§ 2243.5. Policies to Contain Required Provisions and May Contain Optional Provisions; Uniform Provisions.

Every U. C. D. policy issued or delivered by any insurer shall contain the required provisions hereinafter set forth and many contain the optional provisions hereinafter set forth either in the exact language so set forth or in the substance thereof, or in the substance thereof but more favorable to the employees insured or not less favorable to such employees and more favorable to the employer; provided it shall be presumed, subject to the approval of the commissioner, that the policy contains the substance of the required and optional provisions herein set forth if it contains therein in accordance with the rules and regulations for their use those uniform provisions promulgated for use in group disability policies which cover the same subject matter as the required and optional provisions herein set forth, with such changes in the language of such uniform provisions as are necessary to make them fit the coverage provided in the U. C. D. policy, and meet in substance the corresponding applicable requirements for such provisions as herein set forth; provided further that:

(a) The uniform provisions captioned "Entire Contract; Changes," "Notice of Claim," "Claims Forms," "Proofs of Loss" and "Time of Payment of Claim" are the uniform provisions which incorporate the substance of the corresponding required provisions for U.C.D. policies herein set forth.

(b) The uniform provisions captioned "Physical Examination and Autopsy," "Legal Actions," "Cancellation" and "Payment of Claims" are the uniform provisions which incorporate the substance of the corresponding optional provisions herein set forth for use in U.C.D. policies.

(c) In case the uniform provision captioned "Entire Contract; Changes" is used in a U.C.D. policy, there shall be added to the language thereof promulgated for use in group disability policies a phrase reading in substance, "and the provisions of the California Unemployment Insurance Code and the regulations of the Director of the Department of Employment Development which are incorporated by reference in this policy." This phrase shall be added to the enumeration of the writings which constitute the entire contract between the parties, and shall be used in accordance with the requirements set forth in Section 2244.1 hereof.

(d) In the blank in the uniform provision captioned "Time of Payment of Claim" there shall be entered either a period of time not greater than one week, or a period of time greater than one week, together with the phrase "or each week if the claimant so requests."

(e) To the uniform provision captioned "Physical Examination and Autopsy" there shall be added the phrase "except where such right is limited by the California Unemployment Insurance Code."

(f) To the uniform provision captioned "Legal Actions" there shall be added a sentence reading "This provision does not affect in any way any employee's rights to appeal under the California Unemployment Insurance Code."

(g) The uniform provisions captioned "Other Insurance in This Insurer," "Time Limits on Certain Defenses," "Change of Beneficiary," "Insurance With Other Insurers," "Illegal Occupations" and "Intoxicants and Narcotics" may not be used in a U. C. D. policy; but this prohibition

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is without prejudice to the right of the insurer to include in a U. C. D. policy any provision expressly permitted by these rules and regulations, by the regulations of the director or by the C. U. I. Code.

(h) The other uniform provisions which neither cover subject matter of required or optional provisions set forth herein nor are forbidden to be used in U. C. D. policies by the immediately preceding paragraph hereof may, subject to the approval of the commissioner and insofar as consistent with the C. U. I. Code, be used in substance in a U. C. D. policy at the option of the insurer.

NOTE: Authority cited: Section 10270.2, Insurance Code. Reference: Section 10270.2 (f), Insurance Code.

HISTORY

1. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

FORM—REQUIRED PROVISIONS

§ 2243.7. Issuance of Statement of Coverage or Individual Certificate.

Every U. C. D. policy shall contain a provision that the insurer will issue to the employer, for delivery to each employee insured, either a statement of coverage or an individual certificate setting forth a statement as to the insurance protection afforded the employee and to whom payable. If the policy provides for the issuance of a statement of coverage or an individual certificate in the alternative, but does not specify which will be issued, the application shall so specify.

§ 2243.9. Admission of All New Employees.

Every U. C. D. policy shall contain a provision that to the group or class thereof originally insured there shall be added from time to time all employees of the employer eligible to and applying for insurance in such group or class.

§ 2244. Policy Not in Lieu of Workmen's Compensation.

Every U. C. D. policy shall contain a provision in the following form (or in the substance thereof):

"This policy is not in lieu of and does not affect workmen's compensation insurance."

§ 2244.1. Entire Contract. Incorporation by Reference.

Every U. C. D. policy shall contain a provision relative to the contract which shall be in one of the forms set forth in (a), (b) and (c) hereof, appropriate to the basis upon which the policy is issued (or in the substance thereof), but if the policy incorporates by reference in any lawful manner any portion of the C. U. I. Code or the regulations of the director as a part thereof, the form set forth in (c) shall be used with the alternative language noted therein appropriate to the basis upon which the policy is issued:

(a) This policy and the application of the employer constitute the entire contract between the parties.

(b) This policy constitutes the entire contract between the parties.

(c) This policy (the application of the employer) and the provisions of the California Unemployment Insurance Code and the regulations of the Director of the Department of Employment Development which are incorporated by reference in this policy constitute the entire contract between the parties.

NOTE: Authority cited: Section 10270.2, Insurance Code. Reference: Section 10270.2 (f), Insurance Code.

HISTORY

1. Amendment of subsection (c) filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2244.3. Statements in Application and Changes in Policy.

Every U. C. D. policy shall contain a provision relative to statements in the applications and changes in the policy which shall be in one of the forms set forth in (a) and (b) hereof at the option of the insurer (or in the substance thereof):

(a) "In the absence of fraud, all statements made by the employer shall be deemed representations and not warranties and no such statement shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder unless it is contained in a written application.

"No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an executive officer of the insurer and such approval be enclosed hereon.

(b) "In the absence of fraud, all statements made by the employer shall be deemed representations and not warranties and no such statement shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder unless it is contained in a written application.

"No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an executive officer of the insurer and evidenced by endorsement hereon, or by amendment hereto signed by the employer and by an executive officer of the insurer."

§ 2244.5. Notice and Proof of Claim; Alternative Provisions.

Every U. C. D. policy shall contain provisions relative to notice and proof of claim which, at the option of the insurer, shall be either in the short form set forth under (a) of this section (or in the substance thereof) or in all of the forms set forth under (b) of this section (or in the substance thereof) in accordance with the instructions for their use:

(a) First Alternative Required Provision Relative to Notice and Proof of Claim.

"All_____ provided in this policy shall be paid to the employee as they accrue upon receipt of written proof (on the insurer's forms or, if such forms are not furnished by the insurer within fifteen days after demand therefor, then upon receipt of written proof) covering the occurrence, character and extent of the event for which claim is made."

Instructions for Its Use.

This provision may be used, at the option of the insurer, in lieu of any one of the following combinations of provisions under (b): (b):

(b) (1), (2) and (3)

(b) (1), (2), (3) (4) and (5)

(b) (1), (2), (3), (4), (5) and (6)

In the blank space the word "benefits" or other descriptive phrase shall be entered. If this provision is used in combination with the provision under (b) (6), there shall be substituted in lieu of the words, "to the employee as they accrue" contained in this provision, the words "as stated_____" inserting in the blank space the location in the policy of the required provision prescribed under (b) (6).

(b) Second Alternative Required Provisions Relative to Notice and Proof of Claim:

(1) "Written notice of injury or of sickness upon which claim is based must be given to the insurer within twenty days after the date of the commencement of the first loss for which benefits arising out of each such injury or sickness are claimed."

(2) "Notice given by or in behalf of the claimant to the insurer at_____ or to any authorized agent of the insurer, with particulars sufficient to identify the insured employee, shall be deemed to be notice to the insurer."

Instructions for Use of Form (b) (2).

In the blank space, the address at which notice may be given shall be entered. This provision may be omitted if the insurer has conspicuously imprinted on the individual certificate (including supplemental certificates) and the statements of coverage the name of the insurer and the address of its home and branch offices to which notices may be sent. Otherwise, this provision shall be incorporated in the policy if the insurer elects not to use the short form of provision relative to notice and proof of claim set forth under (a) of this section.

(3) "The insurer, upon receipt of the notice required by this policy, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen days after the insurer receives such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(4) "Affirmative proof of loss of time on account of disability for which claim is made must be furnished to the insurer within ninety days after the termination of the period for which claim is made."

(5) "Failure to furnish notice or proof within the time provided in this policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible."

Instructions for Use of Form (b) (5).

If this provision is used in combination with the short form of provision under (a), the words "Notice or" shall be omitted.

(6) "Upon request of the insured employee and subject to due proof of loss the accrued benefits will be paid to the insured employee each _____during any period for which the insurer is liable, and any balance remaining unpaid at the termination of such period will be paid to the insurer immediately upon receipt of due proof.

Instructions for Use of Form (b) (6).

In the blank space there shall be entered either a period of time not greater than one week or a period of time not greater than two weeks together with the phrase "or each week, if the claimant so requests,."

FORM—OPTIONAL PROVISIONS

§ 2244.7. Examination of Insured Employee.

At the option of the insurer, any U. C. D. policy may contain a provision relative to examination of the person of the insured employee, but any such provision shall be in the following form only or in the substance thereof:

"The insurer shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim hereunder except where such right is limited by the California Unemployment Insurance Code."

§ 2244.9. Time Restriction on Institution of Suit on Policy.

At the option of the insurer, any U. C. D. policy may contain a provision relative to the time within which suit may be brought under the policy, but any such provision shall be in the following form only or in the substance thereof:

"No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy, nor shall action be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy. This provision does not affect inn any way any employee's right to appeal under the California Unemployment Insurance Code."

If the insurer elects to use the short form of alternative required provision relative to notice and proof of claim set forth in (a) of Section 2244.5, and to omit the provision set forth under (b) (4) of Section 2244.5, there shall be substituted for the words "from the expiration of the time within which proof of loss is required by the policy" contained in the provision herein above set forth in this section, the words "and ninety days after the termination of the period of disability on which the cause of action is based."

§ 2245. Cancellation by Insurer.

At the option of the insurer, any U. C. D. policy may contain provision relative to the cancellation or termination of the policy at the instance of the insurer, but any such provision shall

(a) Provide for notice to the employer and such notice to the Department of Employment Development as the C. U. I. Code or the regulations of the director require.

(b) State when the cancellation or termination of the policy is to become effective.

(c) Provide for the return to the employer of pro rata unearned premium if the cancellation or termination is made effective at other than a premium due date.

NOTE: Authority cited: Section 10270.2, Insurance Code. Reference: Section 10270.2(f), Insurance Code.

HISTORY

1. Amendment of subsection (a) filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2245.1. Reduction of Benefits Because of Age.

At the option of the insurer, any U. C. D. policy may contain a provision relative to the reduction of benefits because of age, but no such provision shall reduce benefits because of age, but no such provision shall reduce benefits below the amount to which the individual employee insured would be entitled under the C. U. I. Code if he were not covered by a voluntary plan.

HISTORY

1. Repealer of former Section 2245.1 and amendment to present Section 2245.1 (formerly Section 2245.3) filed 5–27–50; effective 30th day thereafter (Register 20, No. 5).
2. Amendment filed 4–4–56; effective thirtieth day thereafter (Register 56, No. 6).

§ 2245.2. Reduction or Proration of Benefits on Account of Simultaneous Coverage.

At the option of the insurer, any U. C. D. policy may contain a provision relative to the reduction or proration of benefits on account of simultaneous coverage under the C. U. I. Code, but any provision shall be in one of the forms set forth in (a), (b), and (c) hereof only, or in the substance thereof. Connective words or phrases may be added, and there may be substituted for such words as "per day," "amount payable," and the like, other words or phrases more consistent with the other terminology used in the policy, but no such additions or substitutions shall be such as to change the substantive effect of the specified provisions.

Form (a) shall be used if the additional benefit while confined to a hospital as provided in the U. C. D. policy is the amount per day provided in the C. U. I. Code for additional benefits during hospital confinement. Form (b) shall be used if the additional benefits while confined to a hospital as provided in the U. C. D. policy is more than such amount per day. There shall be inserted in the blank space in form (a) and in the second blank space in form (b) the amount of the additional benefit during hospital confinement provided at the time of the issuance of the policy by the C. U. I. Code, and in the first blank space in form (b) there shall be inserted the amount by which the additional benefit per day while confined to a hospital exceeds the amount of the additional benefit during hospital confinement as provided in the C. U. I. Code. Form (c) shall be used if the insurer desires, on account of simultaneous coverage, to reduce or prorate basic U. C. D. benefits for loss of time as well as the additional benefits while confined to a hospital. Any of such forms (a), (b) or (c) may, by the terms of the U. C. D. policy, be made applicable to all employees, or to specified classes of employees determined by conditions pertaining to their employment, or to certain specific causes of disability objectively described, or to both such specified classes of employees and such specified causes of disability. From form (c) there may be omitted paragraph (1) in those cases in which the provision is made applicable only to a specified class or classes of employees which by the terms of the policy are entitled to the same benefits to which they would be entitled under the C. U. I. Code were they not covered by any voluntary plan.

Forms:

(a) In case of any day of hospital confinement for which an employee entitled to benefits hereunder is simultaneously covered by one or more other plans (including voluntary plans and the State Unemployment Compensation Disability Fund) and is accordingly entitled to other "additional benefits during hospital confinement" on account of the same

disability, then the $_____per day otherwise payable hereunder shall be divided by the number of plans (including voluntary plans and the State Unemployment Compensation Disability Fund) under which he is simultaneously entitled to "additional benefits during hospital confinement" and the quotient shall be the amount payable hereunder for such day of confinement.

(b) In case of any days of hospital confinement for which an employee entitled to benefits hereunder is simultaneously covered by one or more other plans (including voluntary plans and the State Unemployment Compensation Disability Fund) and is accordingly entitled to other "additional benefits payable during hospital confinement" on account of the same disability, the amount of the "additional benefits payable during hospital confinement" payable hereunder for such day of hospital confinement shall be $_____ plus the quotient of $_____divided by the number of plans (including voluntary plans and the State Unemployment Compensation Disability Fund) under which he is simultaneously entitled to "additional benefits on account of hospital confinement."

(c) In case of any period for which an employee entitled to benefits hereunder is simultaneously covered by one or more other plans (including voluntary plans and the State Unemployment Compensation Disability Fund) and entitled to other Unemployment Compensation Disability benefits on account of the same disability, the amount payable for such period shall be:

(1) The amount, if any, by which the benefits to which the employee otherwise would have been entitled under this policy exceed the benefits to which he would have been entitled under the C. U. I. Code if he were not covered by any voluntary plan, plus

(2) The quotient of the amount of benefits to which the employee would have been entitled under the C. U. I. Code if he were not covered by any voluntary plan divided by the number of plans (including voluntary plans and the State Unemployment Compensation Disability Fund) under which he is simultaneously entitled to benefits.

HISTORY

1. New Sections 2245.2, 2245.3, and 2245.4 filed 5–27–50; effective 30th day thereafter (Register 20, No. 5).
2. Amendment to Sections 2245.2, 2245.3 and 2245.4 filed 4–4–56; effective thirtieth day thereafter (Register 56, No. 6).

§ 2245.3. Benefits Limited etc. Under C. U. I. Code.

Subject to the provisions of Sections 2245.1 and 2245.2, any U. C. D. policy may, at the option of the insurer, contain a provision which limits, reduces or eliminates benefits in the same manner, and to the same extent benefits are or may be limited, reduced or eliminated under the C. U. I. Code and the authorized rules and regulations adopted thereunder.

§ 2245.4. Limitation of Amount of Indemnity.

Except as provided in Sections 2245.1, 2245.2 and 2245.3, no U. C. D. policy shall contain a provision limiting the amount of indemnity to an amount less than that stated in the policy and for which the premium has been paid. A provision in a U. C. D. policy which guarantees to all employees benefits not less than they would be entitled to under the C. U. I. Code if they were not covered by such policy or which limits the benefits payable to a specified class or classes of employees to the same benefits to which they would be entitled under the C. U. I. Code if they were not covered by such policy, shall not be considered to be in conflict with this section or Sections 2245.1, 2245.2 or 2245.3.

§ 2245.5. Facility of Payment.

At the option of the insurer, any U. C. D. policy may contain a facility of payment provisions relative to the payment of benefits to persons other than the individual employee insured out of whose disability the insurer's liability for benefit arises, but any such provision shall be in the following form only or in the substance thereof. In the blank space an amount not exceeding $1,000 shall be inserted.

"All benefits shall be paid to the insured employee, except that (in event the insurer determines that he is incompetent or incapable of executing a valid receipt, the insurer may, during his lifetime, unless claim has been made by a duly appointed guardian or committee, pay any amount otherwise payable to the insured employee to the husband or wife or relative by blood of the insured employee, or to any other person or institution determined by the insurer to be equitably entitled thereto; or) in case of the death of the insured employee before all amounts payable under the policy have been paid, the insurer may pay any such amount to an aggregate of $_____to any person or institution determined by the insurer to be equitably entitled thereto. Any payment in accordance with this provision shall discharge the obligation of the insurer hereunder to the extent of such payment."

ISSUANCE

§ 2245.7. To Whom Policy May Be Issued.

Policies providing U. C. D. benefits may be issued to any employer or association of employees that may apply for and receive approval of a voluntary plan pursuant to Part 2, Division 1 of the C. U. I. Code. Such policies may also be issued to any entity to which may be issued a group disability policy pursuant to the provisions of Section 10270.5 of the Insurance Code, subject, however, to the obtaining of the approval of the director of the voluntary plan or plans which may insured thereby.

§ 2245.9. Who May Be Covered.

Every U. C. D. policy may be issued to cover any person who may be included as an employee under a group disability policy in accordance with Sections 10270.5 or 10270.55 of the Insurance Code, even if not eligible for coverage under the voluntary plan approved by the director, if the purpose and scope of the policy is principally to provide U. C. D. benefits and additional benefits for loss of time on account of disability to eligible employees under an approved voluntary plan.

§ 2246. Insurer to Issue Statement of Coverage or Individual Certificate for Each Employee.

Every insurer shall provide or issue to the employer for delivery to each employee insured under a U. C. D. Policy issued by it, either a statement of coverage which has been approved both as to form and substance by the director or an individual certificate setting forth a statement as to the insurance protection afforded him and to whom payable, which has been approved by the Commissioner.

Article 6.7. Credit Life and Credit Disability Insurance Policy Forms and Administration

§ 2248. Preamble and Authority.

(a) Credit insurance provides important stability in financing the flow of goods and services; protecting the interests of lenders and sellers by assuring payment of outstanding debts, and avoiding hardship to debtors and their families in the event of death or disability of the debtor prior to termination of the debt.

(b) In the marketing of credit insurance there have been occasions where the inferior bargaining position of the debtor creates a "captive market" which, in the absence of appropriate regulation, places the creditor in a position to dictate the choice of coverage, the premium rate, the insurer and agent, with undesirable consequences, such as: excessive coverage both as to amounts and duration; excessive charges to debtors; failure to inform debtors of their insurance coverage; and failure to provide debtors the protection purchased by the debtor.

(c) In the absence of appropriate regulations, premium rates and compensation for credit insurance tend to be set at levels determined by the rate of return desired by the creditor in the form of dividends, or experience–rating refunds or in the form of commissions either to the creditor as a licensed agent or broker controlled or owned by the creditor instead of on the basis or reasonable cost for the protection provided to the consumer, the debtor. This results in "reverse competition" which, unless properly controlled through the regulation of the premium rates charged to the debtor and the amount of compensation received by the creditor, agents

and brokers results in inequitable insurance premium charges to debtors which are unreasonably high and not reasonable in relation to the premium charged for the insurance benefits received by debtors, and constitute provisions which are unjust, inequitable and unfair.

(d) These regulations are promulgated pursuant to Section 779.21 of the Insurance Code and apply to credit life insurance and credit disability insurance which is subject to the subject to the provisions of Article 5.9, Chapter 1, Part 2, Division 1, of the Insurance Code.

NOTE: Authority cited: Section 779.41, California Insurance Code.

HISTORY

1. Repealer of article 6.7 (sections 2248.1–2248.25, consecutive) and new article 6.7 (sections 2248–2248.20, consecutive) filed 12–29–78; designated effective 4–1–79 (Register 79, No. 2). For prior history, see Registers 73, No. 22; 70, No. 18.
2. Amendment of article heading filed 4–14–94; operative 5–18–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

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NOTE: Authority cited: Section 779.21, California Insurance Code.

§ 2248.2. Effective Date.

This Ruling shall become effective on the first day of April, 1979, and shall be applicable to all credit insurance individual policies and certificates transacted thereafter. All Bulletins issued since July 1, 1973 relating to Ruling No. 186 are hereby rescinded.

NOTE: Authority cited: Section 779.21, California Insurance Code.

§ 2248.3. Definitions.

As used in these regulations:

(a) "Credit life insurance," "credit disability insurance creditor," "debtor" and "indebtedness" have the meanings assigned to such terms in Section 779.2 of the Insurance Code.

(b) "Credit insurance" means both credit life insurance and credit disability insurance.

(g) "Application" means any document, including a conditional sales contract, which the debtor signs and which requests credit insurance coverage the debtor, or which authorizes the financing of credit insurance premium or agrees to pay credit insurance premiums.

(h) "Actuary," as used in these regulations, means an actuary who is:

(1) a member of the American Academy of Actuaries, or of the Society of Actuaries or

(2) a person who has engaged in the practice of actuarial science and has demonstrated by his training and experience actuarial competence to the satisfaction of the Commissioner.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Section 779.9, Insurance Code.

HISTORY

1. Amendment of subsections (e) and (h) filed 1–12–79; designated effective 4–1–79 (Register 79, No. 2).
2. Editorial correction of subsection designations (Register 79, No. 2).
3. Amendment filed 6–4–79; effective thirtieth day thereafter (Register 79, No. 23).
3. Repealer of subsections (c)–(f) filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.4. Premiums.

(a) The amount charged to a debtor for any credit life or credit disability insurance shall not exceed the premium rates filed with the Commissioner for the coverage provided or the premiums charged by the insurer, as computed at the time the charge to the debtor is determined, whichever is less.

(b) If the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of the indebtedness and makes any direct or indirect finance, carrying, credit or service charge whatever to the debtor in connection with such insurance charge, the creditor is deemed to have loaned the premium or insurance charge to the debtor and the premium or insurance charge is deemed collected for the insurer as soon as it is added to the indebtedness, in which event, the creditor must remit and the insurer shall collect on a single premium basis only.

(c) A creditor may remit and an insurer may collect premiums on the monthly balance basis on revolving credit accounts.

(d) A creditor may remit and an insurer may collect premiums on the monthly balance basis on indebtedness repayable during a fixed period (non–revolving accounts) for both credit life insurance and credit disability insurance.

(e) When premiums are remitted on the monthly balance basis, either on a revolving account or a fixed indebtedness period basis, the charge for the premium shall be shown separately from the balance of the loan and any payment received by the creditor shall first be applied to pay the credit insurance premium. Only in the event no payment is made or the payment made is insufficient to satisfy the premium charge, may the creditor add the unpaid premium to the loan and remit it to the insurers.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Sections 779.21 and 779.13, California Insurance Code.

HISTORY

1. Editorial correction of subsection referenced in subsection (f) (Register 79, No. 2).
2. Repealer of subsections (f)–(g) and amendment of NOTE filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
3. Amendment of subsection (c) filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2248.5. Claims and Claims Review Procedure.

(a) The insurer shall be responsible for the settlement, adjustment and payment of all claims and shall establish and maintain adequate claim files, which may be reviewed and examined by the Commissioner. All

claims shall be promptly reported to the insurer, or its designated claim representative, and all claims shall be settled as soon as possible in accordance with the terms of the insurance contract.

(b) All claims shall be paid, either by draft drawn upon the insurer or by check of the insurer, directly to the order of the claimant to whom payment of the claim is due under the policy, or to the payee specified by such claimant. If the insurance payable exceeds the balance which the debtor or his estate are obligated to pay to the creditor, the insurer shall pay the excess directly to the person or estate entitled to such excess, or establish procedures to be followed the creditor or make such payments, in which case the insurer must take all reasonable precautions to make certain such procedures are followed.

(c) No person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. Neither the creditor nor the general agent or agent of the insurer shall be designated claim representative for the insurer in settling or adjusting claims. A group policyholder, however, by arrangement with the insurer, may draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

NOTE: Authority cited: Section 779.21, California Insurance Code.

§ 2248.6. Responsibility of Insurers, Life and Disability Insurance Agents and Insurance Agents to Make Review of Transactions.

(a) It shall.be the responsibility of the insurer, all creditors licensed as life and disability insurance agents and insurance agents who receive commissions on credit insurance in connection with the transaction of credit insurance to conduct a review of each creditor account within 120 days after the end of the first year and thereafter a minimum of once each two years for the purpose of assuring compliance with these regulations and all applicable provisions of the Insurance Code, including the calculation of the proper premium and the transmittal of the proper premium to the insurer, and payment of claims and refunds, and make any necessary corrections to comply with the provisions of these regulations.

NOTE: Authority cited: Section 779.21, California Insurance Code.

14 Day Retroactive Plan $2.55

§ 2248.7. Provisions of Policies and Certificates of Insurance: Disclosure to Debtors.

(a) An individual credit insurance policy or a certificate of group credit insurance shall be delivered to the debtor within thirty (30) days after the debtor becomes insured in connection with the indebtedness, as evidence of such insurance.

(b) Each individual policy or group certificate of credit insurance delivered or issued for delivery in this State shall, in addition to the other requirements of law, set forth:

(1) the name and home office address of the insurer, and, on group certificates, an identification of the master policy;

(2) the identity of the insured debtor by name or any other reasonable alternative method of identification approved by the Commissioner;

(3) the full amount of premium or identifiable insurance charge to the debtor, separately for the credit life insurance and credit disability insurance; except that in lieu of so stating the full amount of premium or identifiable insurance charge, there may be set forth, separately for credit life insurance and credit disability insurance, the rate of insurance premium or payment per unit of coverage in case the indebtedness is a revolving loan or charge account or in cases where the debtor obligates himself to pay the insurance premium or payment periodically with the debt payments on the decreasing amount of the insurance;

(4) a description of the coverage including the amount and term thereof;

(5) any exceptions, reductions, limitations and restrictions;

(6) a statement that the benefits will be paid to the creditor to reduce or extinguish the indebtedness, and if the policy provides coverage which may exceed the amount to which the creditor is entitled under the contract of indebtedness, any such excess shall be paid to a beneficiary other than the creditor, named by the debtor or to his estate; and

(7) a statement that in the event the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness, and in the event the indebtedness is discharged due to payment prior to the scheduled maturity date, the insurance in force shall be terminated, unless payments are made to the debtor during the period of disability under the provisions of Section 2248.7(c)(2)(E).

(c) A policy, certificate of credit insurance or notice of proposed insurance shall not contain provisions which would encourage misrepresentation or which are unjust, unfair, inequitable, misleading, deceptive or contrary to law or to the public policy of this State.

(1) A credit life insurance policy violates this subsection if it contains any limitation or exclusion other than as provided in California Administrative Code, Title 10, Chapter 5, Article 6.9.

(2) A credit disability insurance policy violates this subsection if it:

(A) restricts coverage to permanent disabilities where the debtor is in fact totally disabled for the period required by the policy, although such disability may be of temporary nature;

(B) defines disability as an inability to perform any occupation. Disability may be defined as the inability to perform any occupation for which the debtor is reasonably fitted by education, training or experience after the period of total disability has existed for 18 consecutive months. During the first 18 months of disability, the definition must relate the disability to the occupation of the debtor at the time such disability occurred;

(C) restricts benefits to those periods of total disability when the insured is under the regular and continuing care of a physician, but this provision does not limit the right of the insurer to require evidence of actual disability at reasonable intervals in order to justify the continued payment of benefits;

(D) does not set forth clearly on the insured debtor's policy or certificate in bold print or in some other prominent way, the type of benefit payable, i.e., amount of monthly indemnity and a provision that the daily indemnity will be calculated at the rate of 1/30 of the monthly indemnity;

(E) does not provide that if a debtor refinances or renews his indebtedness while disabled and insured, the refinancing or renewal shall be disregarded for the purposes of applying elimination periods and applying waiting periods and applying time limitations applicable to pre-existing conditions to the extent such time limitations had expired prior to such refinancing or renewal to the extent of the amount and term of the insured indebtedness outstanding at the time of the renewal and refinancing of the debt or if the indebtedness is prepaid by the debtor during any period of disability for which benefits are payable, the disability coverage shall either continue in force and the insurer shall make periodic payments directly to the debtor until such time as the disability no longer exists or to the end of the term of insurance, whichever first occurs, or provides for refund of the unearned premium for such period of time;

(F) contains any other exclusion, reduction or limitation except as provided in California Administrative Code, Title 10, Chapter 5, Article 6.9.

(3) A credit life insurance or credit disability insurance policy violates this subsection if it:

(A) contains any exclusion because of age or other eligibility requirement (including, but not limited to employment) unless such requirement is contained in a written application for insurance signed by the insured and such requirement is set forth clearly on the insured debtor's policy or certificate in bold print or in some other prominent method, such as an appropriate caption;

(B) provides an illusory benefit because of a restrictive definition of total disability; for example, a disability policy with a definition of "total disability" which conditions benefits on ability to perform his occupation which is issued to a retired pensioner whose income comes from Social Security, or to a home-maker with no separate wage or salary, or to a member of the armed forces of the United States;

(C) provides an amount of insurance less than the amount necessary to discharge the indebtedness, when it does not set forth clearly such information on the insured debtor's policy or certificate in bold print or in other prominent method.

(4) A notice of proposed insurance violates this subsection if it does not comply with the following:

(A) provides a blank space indicated as the space for signature by the debtor;

(B) sets forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor separately for credit life insurance and credit disability insurance, the amount, term and a brief description of the coverage provided;

(C) refers exclusively to insurance coverage, and shall be separate and apart from the loan, sales or other credit statement of account, instrument or agreement, unless the information required by subparagraph (B) above is prominently set forth therein.

(d) No statements made by a debtor shall be used by an insurer as a basis for denying a claim unless such statement is contained in a written application for insurance signed by the debtor, the form of which has been filed with and approved by the Commissioner for use in connection with the policy form in question.

(e) An application must identify the insurer providing the coverage. An application signed by the debtor is required whenever the policy contains an exclusion on account of age or other eligibility requirement.

(f) By accepting an application and issuing a policy, certificate or notice of proposed insurance, the insurer waives any limitations in the policy which the application revealed were breached on the date the application was made.

(g) If the insurer accepts premiums where the applicant has correctly stated his age, insurance coverage shall be effective regardless of age limitations or exclusions if a premium refund is not actually made (finance instrument amended) within the 75-day period following the date the application for insurance was signed by the debtor.

(h) A group credit insurance policy which provides for payment of single premiums to the insurer shall provide that, in the event of termination of such policy by the insurer or creditor, insurance coverage with respect to any debtor insured under such policy, shall, unless the debt is refinanced or prepaid, be continued for the entire period for which a single premium has been paid by such debtor. A group credit insurance policy under which premiums are paid to the insurer monthly on outstanding balances shall contain a provision that, in the event of termination of such policy by the insurer or creditor, thirty-one days notice of such termination shall be given to any debtor insured under the policy by the insurer where practicable, otherwise by the creditor, unless there is immediate replacement of the coverage by the same or another insurer. With respect to debtors covered at the date of termination where notice is required, coverage shall continue until notice is given as though the policy had not terminated.

(i) Currently Approved Policy Forms. Nothing in these regulations require the refiling of currently approved policy forms, riders or any other approved forms. It is recognized that certain provisions of these regulations will require the refiling of rates and the reprinting of rate charts. Such currently approved forms shall be construed, however, to be in compliance with all provisions of these regulations, or the insurer shall immediately notify the Insurance Commissioner that the insurer will not issue any such forms hereafter, and will not enroll or insure any new debtors on such forms on and after the effective date of these regulations. New policy forms, riders and applications filed for approval on and after the effective date of these regulations, April 1, 1979, shall comply with all provisions of these regulations.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Sections 779.5 through 779.9 and 779.14, California Insurance Code.

HISTORY

1. Amendment of subsection (b) and NOTE filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.8. Refund Formula.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Editorial correction of subsection designations (Register 79, No. 2).
2. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.9. Premium Rates.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Section 779.9, Insurance Code.

HISTORY

1. Amendment file 1-12-79; designated effective 4-1-79 (Register 79, No. 2).
2. Editorial correction of subsection designations (Register 79, No. 2).
3. Amendment filed 6-4-79; effective thirtieth day thereafter (Register 79, No. 23).
4. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.10. Rate Deviations.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Section 779.9, Insurance Code.

HISTORY

1. Amendment of subsections (b)(3)(B)2.b., (c)(1)(A) and (c)(1)(G) filed 1-12-79; designated effective 4-1-79 (Register 79, No, 2).
2. Editorial correction of subsection designations (Register 79, No. 2).
3. Amendment filed 6-4-79; effective thirtieth day thereafter (Register 79, No. 23).
4. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.11. Compensation.

NOTE: Authority cited: section 779.21, California Insurance Code. Reference: Section 779.9, Insurance Code.

HISTORY

1. Amendment filed 1-12-79; designated effective 4-1-79 (Register 79, No. 2).
2. Amendment filed 6-9-79; effective thirtieth day thereafter (Register 79, No. 23).
3. Repealer filed 10-2-2006; operative 11-1-2006 (Register 2006, No. 40).

§ 2248.12. Compensating Balances or Special Deposits Prohibited.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Editorial correction of subsection designations (Register 79, No. 2).
2. Repealer filed 10-2-2006; operative 11-1-2006 (Register 2006, No. 40).

§ 2248.13. Reinsurance Through Non-Admitted Insurers.

(a) In the matter of reinsurance ceded to a non-admitted insurer, attention of all insurers writing credit insurance in this State is directed to the provisions of Sections 922.4 and 922.5 of the Insurance Code. These sections will be strictly enforced by the Commissioner. As a practical matter, an insurer will normally qualify for any reserve credits by satisfying the requirements of 922.4 (b), 922.5 (a) or 922.5 (c) of the Insurance Code.

(b) The Commissioner may require a detailed accounting of deposits to, withdrawals from, and balances of, or may at any time examine, any or all deposits or funds held by or for the admitted insurer as the basis for such claim of reinsurance credit.

NOTE: Authority cited: Section 779.21, California Insurance Code.

§ 2248.14. Minimum Financial Statement Reserves.

(a) The minimum reserve standards on individual credit insurance policies and roup credit insurance policies are as follows:

(1) Credit Life Insurance.

(A) Individual policies—the reserve must not be less than a reserve based on the Commissioner's 1958 Standard Ordinary Mortality Table at 4 percent annual interest.

(B) Group Insurance—the reserve must not be less than a reserve based on the Commissioner's 1960 Standard Group Mortality Table at 4 percent annual interest.

(2) Credit Disability Insurance. The reserve must not be less than a reserve based on 130 percent of the 1964 Commissioner's Disability Table at 4 percent annual interest. However, under the provisions of Insurance

Code Section 997(a), should an insurer, after establishing a credit disability reserve on the basis of 130 percent of the 1964 Commissioner's Disability Table, develop a total aggregate disability reserve for all disability policies (including non-credit disability insurance reserve) which is less than the pro rata gross unearned premium reserve for all such policies, then an additional reserve must be established so that such aggregate total shall not be less than such gross pro rata unearned premium reserve.

(b) Where a credit insurance policy provides both life insurance benefits and disability benefits, a reserve must be established separately for all the life insurance benefits and disability benefits. Life and disability insurers shall include such credit disability reserve in Exhibit 9 of the Life and Accident and Health Annual Statement.

(c) Section 997(a) of the Insurance Code provides that for statement purposes, for insolvency calculations, and for the valuation of the liabilities of insurers for all other purposes, every admitted insurer shall maintain an active life reserve which shall place a sound value on its liabilities under all disability policies which, in no event, shall be less in the aggregate than the pro rata gross unearned premium reserve for such policies.

(1) A credit disability insurance reserve deemed to satisfy the requirements of Section 997(a) of the Insurance Code for single premium credit disability insurance plans is either:

(A) the product, rounded to the next higher dollar, of

1. The gross prima facie single premium rate per thousand dollars of insured indebtedness for the term of the indebtedness remaining as of the valuation date, times

2. The number of thousands of dollars of indebtedness outstanding as of the valuation date, times

3. The ratio of the premium rate charged to the prima facie rate, or

(B) Obtained by use of tables of reserve factors available from the California Department of Insurance at a cost of $50 per set of factors.

(2) For plans with monthly premiums payable on non revolving accounts on the amount of indebtedness outstanding a credit disability insurance reserve deemed to satisfy the requirements of Section 997 (a) of the Insurance Code is defined according the following procedure for a particular plan.

(A) Determine the ratio of:

1. The gross single premium from which the monthly premiums were derived to

2. The total of the monthly premiums payable during the period of the plan.

(B) Determine the earned premium from the date of issue to the valuation date.

1. On the gross single premium basis this is the gross single premium less the unearned premium reserve as of the valuation date as defined in paragraph (1) of this subsection.

2. On the monthly premium basis this is the total of all monthly premiums collected from the issue date to the valuation date multiplied by the ratio determined in (A) above.

(C) The required unearned premium reserve as of the valuation date is the excess of (B) 1. over (B) 2.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Section 779.9, Insurance Code.

HISTORY

1. Amendment filed 6-4-79; effective thirtieth day thereafter (Register 79, No. 23).
2. Amendment of subsections (c)(1)(A)1-2, repealer of subsection (c)(1)(A)3 and amendment and redesignation of subsection (c)(1)(A)4 filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.15. Annual Experience Statistics Reporting.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.16. Department of Insurance Form.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.17. Annual Experience Report Forms.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.18. Deviated Rate Calculation Form CDEV.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.19. Disabled Lives Reserve Development Form CDP.

NOTE: Authority cited: Section 779.21, California Insurance Code.

HISTORY

1. Repealer filed 10-2-2006; operative 11-1-2006 (Register 2006, No. 40).

§ 2248.20. Rate Tables and Reporting Forms.

NOTE: Authority cited: Section 779.21, California Insurance Code. Reference: Section 779.9, Insurance Code.

HISTORY

1. Amendment of form CDEV filed 6-4-79; effective thirtieth day thereafter (Register 79, No. 23).
2. Repealer filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

Article 6.8. Credit Life and Credit Disability Insurance: Premium Rates

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NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Section 779.36, Insurance Code.

HISTORY

1. New article 6.8 and section filed 4-14-94; operative 5-16-94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) Register 94, No. 15).
2. Amendment deleting reference to repealed section 2248.48 filed 10-2-2001; operative 10-1-2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).

§ 2248.31. Definitions.

All words or phrases not defined in this Section shall have the same meaning in these regulations as they have in Article 5.9 of Chapter 1 of Part 2 of Division 1 of the Insurance Code, starting with § 779.1. As used in this Article:

(a) "Actuarially equivalent" means having a pattern of rates and benefits or of premium refunds and remaining coverage which can be demon-

strated to be equivalent to another pattern of rates and benefits or of premium refunds and remaining coverage by the application of contingency, interest and discount factors or otherwise.

(b) "Class A Decreasing Life" provides a life insurance benefit which decreases in accordance with the scheduled decline in Closed End debt principal except that it covers any delinquent payments, pursuant to Financial Code §§ 18291 and 22314(e). This coverage is provided by standard policy forms ID numbers 6 through 9 in Article 6.9 of this Subchapter.

(c) A "Closed End" plan of indebtedness provides for repayment, in substantially equal payments, of a principal amount for a term and at an interest rate, all of which are fixed at the commencement of the term of the debt.

(d) "Credit Card" is an Open End plan of indebtedness based upon the use of a "credit card", as defined in Civil Code § 1747.02(a).

(e) "Credit Union Open End" is an open end plan of indebtedness extended by a credit union which provides for periodic payments, often in

substantially equal amounts, which may be adjusted from time to time if the insured increases the outstanding debt or repays the loan faster than required. Coverage of this plan of indebtedness is provided by standard policy forms ID numbers 18 through 22 in Article 6.9 of this Subchapter.

(f) "Earned premium" is computed as follows:

(1) Where premiums are collected on a single premium basis for the entire term of coverage:

Single premiums which became due the insurer during the experience period

- The unearned premium reserve* at the end of the experience period
+ The unearned premium reserve* at the end of the previous experience period
- Premium refunds or adjustments resulting from termination of coverage
= Earned Premium (single premium basis)

* See subparagraph (4).

(2) Where premiums are payable monthly during the term of coverage:

Monthly premiums paid the insurer during the experience period

+ Monthly premiums due the insurer but unpaid at the end of the experience period
- Monthly premiums due the insurer but unpaid at the end of the previous experience period
- Unearned premium reserve* at the end of the experience period
+ Unearned premium reserve* at the end of the previous experience period
- Premium refunds or adjustments resulting from termination of coverage

= Earned Premium (monthly basis)

*See subparagraph (5).

(3) Dividends, experience refunds or any other reductions of premium after issuance of coverage shall not be subtracted from earned premium nor included in benefits.

(4) The unearned premium reserve for single premium life plans equals the single premium for the amount and term of the remaining indebtedness. The unearned premium reserve for single premium disability plans is the single premium for the sum of the remaining loan payments and the remaining term of the loan.

(5) The unearned premium reserves for monthly premium life plans and disability plans equal the unearned portions of the gross premiums in force. This depends on the distribution of due dates through the month. The calculation shall be made consistently from month to month. For example, the unearned premium reserve for monthly business can only be zero if all due dates are at the first of the month.

(g) "Incurred claims" are computed as follows:

Claims paid during the experience period

+ Claim reserve at the end of the experience period

- Claim reserve at the end of the preceding experience period

= Incurred Claims

Where: "Claims" means benefits payable during the experience period because of death or disability without additions of any kind. A disability claim is deemed incurred on the date when disability commenced.

"Claim reserve" is the sum of the reserves for claim liability on disabled lives, claims incurred but not reported and claims due but unpaid. The Commissioner may disallow that part of any claim reserve which is unsupported by provable data.

(h) "Joint Disability" insures two persons jointly liable for an indebtedness on any plan. The full monthly benefit becomes payable on the disability of the first insured to become disabled.

(i) "Joint Life" insures two persons jointly liable for the indebtedness on any of the above plans. The full life insurance benefit is paid and coverage terminates on the death of the first insured. This coverage is represented by standard policy form text blocks PC 3 and PD 1 of § 2249.12 of this Chapter.

(j) "Level Life" provides a constant fixed benefit over the term of coverage. This coverage is provided by standard policy forms ID numbers 16 and 17 in Article 6.9 of this Subchapter.

(k) "Line of Credit" is any Open End plan of indebtedness that is not a "Credit Union Open End" plan or a "Credit Card" plan. It includes "lines of credit", variable interest rate loans and revolving accounts other than "credit cards".

(*l*) An "Open End" plan of indebtedness is one in which one or more of the following are variable at the creditor's or the debtor's option – the principal amount, the term of the indebtedness, the number of payments, the amount of each payment or the interest rate.

(m) "Scheduled Decreasing Life" (sometimes called "net balance life") provides a life insurance benefit which decreases in accordance with the scheduled decline in Closed End debt principal. This coverage is provided by standard policy forms ID numbers 11 through 14 and 25 through 28 in Article 6.9 of this Subchapter.

(n) "Premium" means the premium amount charged or the insurance charge made for the insurance actually provided.

(o) "Prima facie rates" means the maximum rates which reasonably can be expected to provide the presumptive loss ratio referred to in Ins. C. § 779.36 and the relationship of benefits to premiums required by § 779.9.

(p) "Rate" means the amount charged per unit of insurance coverage.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.2, 779.4, 779.9, 779.30(f), 779.36, Insurance Code; Sections 18290, 18291, 22314, 22315 and 22455, Financial Code; and Section 1747.02(a), Civil Code.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
3. Editorial correction of first paragraph and subsections (b), (d), (i) and (*l*) (Register 2001, No. 49).
4. Amendment of subsection (f)(2) filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.32. Presumptive Loss Ratios and Prima Facie Rates, Generally.

(a) The Presumptive Loss Ratios (PLRs) for credit life insurance coverage and for credit disability insurance coverage shall be those indicated below. For the purpose of Insurance Code § 779.9 it shall be presumed that benefits provided in a policy or certificate are not reasonable in relation to the premium charge if the claims incurred thereunder cannot be reasonably expected to equal the PLR below of the premiums earned separately thereunder for credit life insurance or for credit disability insurance.

The PLRs are shown in the table below:

Credit Life Insurance	*Class*	*Single life*	*Joint life*
Closed End	A–E	54.47%	54.24%
Open End Line of Credit	A,B,D,E	54.71%	54.31%
Credit Card	A,B,D,E	54.71%	54.31%
Credit Union Open End	C	54.60%	54.35%
Credit Union Credit Card	C	54.60%	54.35%
Credit disability Insurance	A	58.73%	73.41%
	B	56.34%	70.43%
	C	59.13%	73.91%
	D	59.64%	74.58%
	E	54.91%	68.64%

Note the PLR can be expressed as 56.34% or .5634 when used in a formula.

(b) The prima facie rates set forth in these regulations:

(1) Assume that identical coverage (including maximum amounts and terms of coverage) is offered or provided to all debtors of age 65 or less, and Open–end coverages typically terminate at age 65;

(2) Assume that coverages are subject to the limitations and eligibility standards established for standard policy forms in Article 6.9 of this Subchapter.

(c) Rates computed as set forth in these regulations may be rounded to the nearest cent.

(d) The Commissioner waives the filing under Insurance Code § 779.8 of premium rate schedules conforming to the rates set forth in these regulations when such schedules are used with the standard policy and certificate forms set forth in Article 6.9.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.8, 779.9, 779.13 and 779.16, Insurance Code; Sections 18290, 22458.1 and 24458.1, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal.3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of subsection (a) filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
3. Editorial correction of subsection (a) (Register 2001, No. 49).
4. Amendment of subsections (a) and (b)(1) filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.33. Classes of Business.

"Class of Business" means credit insurance providing coverage within one of the following groupings:

Class A. Industrial Banks – credit insurance subject to Financial Code §§ 18290–18292; California Finance Lenders – credit insurance subject to Financial Code §§ 22314 and 22315. ("Regulated loans.")

Class B. All business not otherwise classified.

Class C. Credit unions, subdivided by occupation group. Where the members of a credit union are classifiable in more than one occupation group, the credit union will be classified according to the grouping applicable to at least 60% of its members. Where this is not possible, the credit union shall be assigned to Occupation Group II.

Occupation Group I – Office Workers and Professionals. This group includes, but is not limited to, credit unions comprised of office workers and professionals employed by, or members of:

(1) Churches or religious organizations;

(2) Cooperatives;

(3) Communications industry including radio, television and telephone;

(4) Educational institutions, associations or services;

(5) Financial institutions, associations or services;

(6) Fraternal and civic groups;

(7) Government office workers (federal, state and local) excluding those related to police, fire protection, military service or postal service;

(8) Legal services;

(9) Medical institutions, associations or services;

(10) Labor unions associated with the respective occupation group served.

Occupation Group II – Light Industry, Security Services, Postal Workers. This group includes, but is not limited to, credit unions comprised of skilled and semi–skilled workers and professionals employed by, or members of:

(1) Agriculture and forestry industries;

(2) Airlines which are regularly scheduled;

(3) Apparel and garment industry;

(4) Appliance manufacturing industry;

(5) Chemical and drug industry;

(6) Construction industry (excluding unskilled laborers);

(7) Entertainment and recreation industries;

(8) Fire protection organizations;

(9) Food processing industries including meat packing, dairy, canning, beverage and grain;

(10) Government employees with inspection duties;

(11) Military and police services;

(12) Postal workers;

(13) Printing industry;

(14) Repair and maintenance industries;

(15) Tobacco industry;

(16) Labor unions associated with the respective occupation group served.

Occupation Group III – Heavy Industry and Transportation. This group includes all credit unions whose membership includes unskilled laborers or which include employees of, or members of:

(1) Automobile, truck, farm implement and equipment manufacturing industries;

(2) Leather and furniture products industry;

(3) Lumber and paper mill industry;

(4) Machinery manufacturing industry;

(5) Metal products, primary or fabricated, industry including foundries, container manufacturers, casting and drop forges, etc.;

(6) Mining industry;

(7) Ordnance industry;

(8) Petroleum, rubber and plastic products industries;

(9) Stone, clay and gypsum products industries;

(10) Transportation including nonscheduled airlines, bus, longshoreman, ocean and inland waterways, railways, urban transit, teamsters but excluding regularly scheduled airlines;

(11) Labor unions affiliated with respective occupation group served.

Class D. Finance companies – installment sales finance; Industrial Banks and California Finance Lenders – loans other than Class A or Class E.

Class E. Banks and savings and loan associations – home improvement loans, other loans secured by real estate, and mobile home loans; mobile home dealers; home improvement contractors and dealers (including swimming pool dealers); Industrial Banks and California Finance Lenders – loans secured by real estate; land development companies – loans secured by real estate; mortgage loan companies specializing in second trust deeds.

Class F. Banks and production credit associations – agricultural and horticultural loans.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.4, 779.9 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal.3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
3. Editorial correction of second and fourth paragraphs (Register 2001, No. 49).

§ 2248.34. Prima Facie Premium Computation for Life Coverages.

(a) Prima facie premiums for Closed End life coverages ("Scheduled Decreasing Life", "Class A Decreasing Life" and "Level Life") are computed as follows:

(1) Single premium single life:

$$\text{Single Premium} = MP \sum_{t=1}^{n} \frac{Ins^t/1000}{(1+.042/12)^{t-1}}$$

Where: n = number of months of coverage

t varies from 1 to n

(This formula calculates the present value of monthly premiums for each month of the term of the loan. The present values are then accumulated to determine the single premium.)

(2) Monthly premium single life:

$$\text{Monthly Premium} = MP \times \frac{Ins^t}{1000}$$

Where: MP is the Closed End Monthly Premium per $1000 of scheduled outstanding balance of the indebtedness from TABLE 1 in § 2248.47.

Ins^t is the lesser of the scheduled principal balance of the debt

outstanding for month "t" (not including delinquencies or unearned finance charges) or the amount of insurance for month t (for partial coverage).

(b) Prima facie monthly premiums for Open End life coverages ("Credit Union Open End", "Line of Credit" and "Credit Card") are computed as follows:

$$\text{Monthly Premium} = MP \times \frac{Ins^t}{1000}$$

Where: MP is the Open End Monthly Premium per $1000 of scheduled outstanding balance of the indebtedness from TABLE 1 in § 2248.47.

Ins^t the scheduled principal balance of the debt outstanding for month "t" (not including delinquencies or unearned finance charges) or the amount of insurance for month t provided for in the policy or certificate, if less.

The balance to which the rate is applied may be computed on the same basis as that used to compute interest charges on the debt.

(c) Rates for "Joint Life" coverages are computed by applying the Joint Life Multiplier In TABLE 1 to the appropriate Monthly premium.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.4, 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22458.1, 22458.2 and 24458.1, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal.3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).

§ 2248.35. Prima Facie Premium Computation for Disability Coverages.

(a) Single and monthly premiums for single disability coverage of Closed End loans, where coverage extends for a period measured from the inception of coverage, are computed as follows:

$$\text{Single Premium} = \frac{SP \text{ (for the term of coverage)} \times \text{(Total of covered disability benefit payments)}}{\$1000}$$

$$\text{Monthly Premium for Month "t"} = \frac{MP \text{ (for the initial term of coverage)} \times \text{(Scheduled total of covered disability benefit payments remaining on Month "t")}}{\$1000}$$

Where SP and MP are taken from the lettered Subtable, corresponding to the Class of Business, of TABLE 2 in § 2248.47.

(b) Prima facie monthly premiums for single Open End disability coverages ("Credit Union Open End", "Line of Credit" and "Credit Card") are computed as follows:

$$\text{Monthly Premium} = MP \times \frac{Ins^t}{1000}$$

Where: MP is the Open End Monthly Premium per $1000 of outstanding principal balance (not including unearned finance charges) from TABLE 3 in § 2248.47.

Ins^t is the outstanding principal balance of the debt outstanding for month "t" (not including unearned finance charges) or the amount for month t provided for in the policy or certificate, if less.

The balance to which the rate is applied may be computed on the same basis as that used to compute interest charges on the debt.

(c) Prima facie premium rates for "Critical Period Disability" coverage, as provided for in Article 6.7, shall be actuarially equivalent to the prima facie disability rates for the corresponding coverage under subsections (a) and (b) and shall be approved by the Commissioner pursuant to § 2248.43.

(d) Prima facie rates for "Joint Disability" coverages are computed by multiplying the appropriate single disability rates by 1.6.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290 – 18292, 22458.1, 22458.2, 24458.1 and 24458.2, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal.3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of subsection (b) filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.36. Agricultural and Horticultural Loans.

(a) Rates for coverage on agricultural and horticultural loan commitments as defined in Ins. C. § 10203.35 shall be deemed not reasonable in relation to the benefits provided if they fail to attain the presumptive loss ratios established by § 2248.32(a) based upon experience developed in the preceding 3 years. Such experience may be adjusted for credibility using the Credibility Table in § 2248.40(b). Such rates shall be filed with the Commissioner annually, along with loss experience for the preceding three years, regardless of whether such rates have been adjusted for the year of filing.

(b) Section 2248.32, except for Subsection (a), and §§ 2248.34, 2248.35, 2248.37 and 2248.39 through 2248.42 do not apply to insurance covering agricultural and horticultural loan commitments as defined in Ins. C. § 10203.55.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16, 10203.5 and 10203.55, Insurance Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal.3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.37. Rates By Age.

Age–banded rates may be used upon the Commissioner's approval. The Commissioner shall not approve such rates unless:

(a) They are actuarially equivalent to the prima facie rates established by this Article based upon demonstrated mortality or morbidity rates for each age band and the margins for insurer expenses and profit assumed in the prima facie rates;

(b) They would produce an aggregate premium which would not substantially exceed that which would be produced by the prima facie rates, assuming a normal distribution of debtors by age within the experience group for the Class of Business.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290 – 18292, 22458.1, 22458.2, 24458.1, 24458.2, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal.3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.38. Life and Disability Premium Refunds.

(a) Refunds of single premiums pursuant to Insurance Code § 779.14 shall not be less than amounts calculated as follows:

(1) For life insurance, the single premium for the scheduled remaining insured amount and term of coverage.

(2) For disability insurance:

Refund = Original Single Premium X (t/n)(SPt/SPn) – $10

Where:

- t = the remaining term in months
- n = the original term in months
- SPt = the single premium per $1000 remaining insured amount
- SPn = the original single premium per $1000 initial insured amount

(3) Refunds of less than $5.00 per policy or certificate need not be made. If insurance has terminated due to refinancing of the covered indebtedness and new credit insurance is provided by the same insurer on the refinanced indebtedness, the entire refund amount, including the minimum refund provided for herein and the $10 retention provided for in paragraph (2) (if the terminated indebtedness was insured for disability), shall be applied toward the premium for the new credit insurance.

(b) No refund of monthly life or disability premiums is required. Any monthly premium collected on a billing date after the effective date of termination of coverage shall be refunded without any reduction whatsoever.

(c) Single disability premiums shall be refunded as provided in this section when coverage terminates due to death.

(d) For purposes of this Section, partial months of coverage shall be computed on a daily prorata basis. Alternatively, a partial month of coverage of 15 days or less shall be ignored; a partial month of coverage exceeding 15 days shall be counted as a whole month. Insurers shall use the same method of computing partial months of coverage for all debtors of a given creditor covered by the same plan of benefits.

(e) This Section does not supersede any other statute or regulation which would require a greater refund.

(f) The Commissioner hereby waives the filing, under Insurance Code § 779.14, of refund formulas which are the same as those set forth in this Section.

NOTE: Authority cited: Section 779.21, Insurance Code. Reference: Section 779.14, Insurance Code.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.39. Test for Deviated Rates.

(a) An insurer shall use life insurance rates and disability insurance rates lower than the prima facie rates for an experience group if the credibility adjusted loss ratio for that group is equal to or less than the Presumptive Loss Ratio (PLR) less .05.

(b) An insurer may use life insurance rates and disability insurance rates higher than the prima facie rates for an experience group when the credibility adjusted loss ratio for that group equals or exceeds PLR + .05.

(c) For the purpose of applying this Section to life insurance and disability insurance, credibility adjusted loss ratios shall be computed according to § 2248.40(c) for the most recent experience period, based upon the applicable prima facie rates for the experience group.

(d) Rates which are lower or higher than the prima facie rates shall not exceed the new case rates for the experience group computed according to § 2248.40 and shall be administered pursuant to § 2248.41 or § 2248.42, respectively. Rates shall be calculated and applied separately for life and for disability.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).

§ 2248.40. Calculation of the New Case Rate.

(a) As used in §§ 2248.39 through 2248.42:

(1) "Experience group" means the experience under a plan of insurance of one creditor or more than one creditor. For the purpose of defining and using experience group for life insurance and for disability insurance the separate plans of insurance are: Class, as defined in § 2248.33; life/disability; single life/joint life; open end/closed end; and, single premium/monthly premium. In addition, for disability insurance separate plans also include elimination period and retroactive/nonretroactive for disability. The insurance plans of each creditor in a multiple creditor group must be reasonably similar and each creditor–plan must provide the same type of life or disability coverage (from § 2248.31) and be in the same Class of Business (from § 2248.33).

For purposes of determining deviated rates, the Commissioner may allow a combination of experience groups for single life/joint life for life and disability insurance, and elimination period, retroactive/nonretroactive for disability insurance to maintain an appropriate relationship between rates, where such combination is justified by the carrier to the satisfaction of the Commissioner.

If an experience group has experience in more than this State, an insurer may use only the experience of the experience group in the State to rate the group or, with the approval of the Commissioner, an insurer may use the multi–State experience of the experience group for this purpose if it is more credible than the California experience and is generated by the same or similar plans of insurance and is adjusted to account for differences in premium rates.

Insurers using multiple–creditor groups for the purpose of determining downward or upward deviated rates shall establish written standards for the inclusion of individual creditor–groups within such multiple creditor groups. Such standards shall be applied uniformly regardless of the type of deviation contemplated.

(2) "Experience period" means the most recent period of time for which experience is reported, but not for a period longer than three full years. An experience period shall end on December 31st of each calendar year.

(A) If an experience group develops a Credibility Factor of 1 from TABLE 4 ("Rate Deviation Credibility Table" in § 2248.47) in less than three years, the experience period for that case will be the number of full years needed to attain that Credibility Factor.

(B) An insurer may elect a level of credibility within the range of TABLE 4 for an experience group. If an experience group develops the minimum credibility elected by the insurer in less than three years, the experience period for that group may be, at the option of the insurer, either the number of full years needed to develop the elected minimum credibility or three full years. If an experience group fails to attain such minimum credibility within three full years, the credibility actually attained in that period shall be used for determining downward deviated rates.

Experience incurred in the period immediately preceding the effective date of this regulation may be used to the extent necessary to fill out the experience period.

(C) If a new experience group of an insurer has experience in this State with a prior insurer, the new insurer must use the most recent experience of the experience group with the prior insurer to the extent necessary to fill out an experience period. Other data or projections may be used if the Commissioner finds them to be more credible.

(3) "Incurred Claim Count", as used in TABLE 4, means the number of claims incurred for the experience group during the experience period. This means the total number of claims reported during the experience period, whether paid or in the process of payment plus any incurred but not reported (IBNR) at the end of the experience period less the number of claims incurred but not reported at the beginning of the experience period. If a debtor has been issued more than one policy or certificate for the same plan of insurance, only one claim is counted. If a debtor receives disability benefits, only the initial claim payment for that period of disability is counted.

(4) "Average Number of Life years", as used in TABLE 4, means the average number of group certificates or individual policies in force during the experience period (without regard to multiple coverage) times the number of years in the experience period, or some equivalent calculation.

(b) Find the Credibility Factor ("Z") from TABLE 4 for the experience group. For life insurance, and for disability insurance, where actual loss ratios are less than 45%, use the Average Number of Life years; otherwise, use either the Average Number of Life Years or the Incurred Claims Count. If either of these measures cannot be directly determined, the Commissioner may accept reasonable approximations of them.

(c) For life insurance and for disability insurance, calculate the credibility adjusted loss ratio ("CLR") for the experience group using the following formula, where ALR is the actual loss ratio for the experience group on the prima facie rate basis.

$$CLR = Z\,(ALR) + PLR(1-Z)$$

Calculate the new case rate ("NCR") for the experience group according to the formulas below, where PFR is the prima facie rate for the experience group.

(1) Where CLR is equal to or less than PLR less .05, the downward deviated rate may not exceed the new case rate ("NCR") calculated as:

$$NCR = PFR\,[1 - (PLR-CLR)]$$

(2) Where CLR exceeds PLR + .05, the upward deviated rate may not exceed the new case rate ("NCR") calculated as:

$$NCR = PFR\ [1 + 1.2(CLR-PLR)]$$

(d) Calculations for new case rates or deviated rates under Class A shall use two adjustments, before and after applying the formulas. First, adjust the earned premiums by deducting 10 cents per 1000. Apply the formulas and then add back 10 cents per 1000 to obtain the final new case or deviated rate.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
3. Amendment of subsections (a)(1), (c)(1) and (d) filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.41. Application of Downward Deviated Rates.

(a) For life insurance and disability insurance, an insurer shall submit, for the Commissioner's approval, proposed downward deviated rates for an experience group subject to § 2248.39(a) within 180 days after the end of an experience period during which the credibility adjusted loss ratio for the group was equal to or less than PLR less .05.

(b) Credibility adjusted loss ratios using prima facie rates and new case rates shall be redetermined on each anniversary of the effective date of downward deviated rates for an experience group.

(1) For life insurance and disability insurance, if the credibility adjusted loss ratio for the experience group as of the time of redetermination equals at least PLR less .05, the insurer may submit, for the Commissioner's approval, a proposal for termination of downward deviated rates for the experience group.

(2) If the rates in effect as of such redetermination exceed by 10% or more the new case rates, then the insurer shall submit for the Commissioner's approval, proposed reduced rates which shall not exceed the new case rates. This submission shall be made within 180 days of the date as of which the new case rates were determined.

(3) If the new case rates exceed the rates in effect as of such redetermination, then the insurer may submit, for the Commissioner's approval, increased rates not to exceed the new case rates.

(c) The Commissioner shall disapprove submissions of proposed reduced rates pursuant to subsections (a) and (b)(2) if it is not demonstrated to him or her that they have been determined in accordance with applicable statutes and regulations. The Commissioner may approve modifications of downward deviated rates computed in accordance with §§ 2248.40 if it is demonstrated to his satisfaction that the rates so computed provide inadequate allowances for expenses, reserves or profits or are inconsistent with other reasonable actuarial considerations.

Approved downward deviated rates shall become effective for the experience group within 60 days of the Commissioner's approval. The Commissioner may approve a later effective date if it is demonstrated to him or her that the approved rates cannot reasonably be implemented within 60 days of his approval.

(d) The Commissioner may disapprove proposed increased deviated rates if it is not demonstrated to him or her that they have been determined in accordance with applicable statutes and regulations. The Commissioner may disapprove the termination of downward deviated rates for an experience group if it is not demonstrated to him or her that the credibility–adjusted loss ratio was calculated in accordance with applicable statutes or regulations. Increased downward deviated rates or the termination of downward deviated rates may become effective at any time after the Commissioner's approval or upon the 120th day following the submission of such proposals if they have not been disapproved by that day.

(e) An insurer assuming the business of some or all of the creditors comprising an experience group subject to downward deviated rates shall not use rates exceeding such deviated rates except as provided in subsection (b), above.

(f) An insurer may transfer a creditor from an experience group subject to downward deviated rates to another experience group only if transfer would not result in a higher rate for the remainder of the former group.

(g) Calculations for new case rates or deviated rates under Class A shall use two adjustments, before and after applying the formulas. First, adjust the earned premiums by deducting 10 cents per 1000. Apply the formulas and then add back 10 cents per 1000 to obtain the final new case or deviated rate.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
3. Amendment of subsections (b)(1) and (g) filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.42. Approval and Use of Upward Deviated Rates.

(a) For life insurance and disability insurance, an insurer may submit, for the Commissioner's approval, proposed upward deviated rates for an experience group subject to § 2248.39(b) after the end of an experience period during which the credibility adjusted loss ratio for the group equaled or exceeded PLR + .05.

(b) Credibility adjusted loss ratios using prima facie rates and new case rates for an experience group subject to upward deviated rates shall be redetermined as of each anniversary of the effective date of such rates for the group.

(1) For life insurance and disability insurance, if the credibility adjusted loss ratio for the experience group as of the time of redetermination does not attain at least PLR + .05, then the insurer shall terminate such upward deviated rates within 180 days of the end of the experience period during which the credibility adjusted loss ratio failed to attain PLR + .05. Insurers shall notify the Commissioner of the termination of upward deviated rates.

(2) If the rates in effect as of such redetermination exceed by 10% or more the new case rates, then the insurer shall submit, for the Commissioner's approval, proposed reduced rates which shall not exceed the new case rates. This submission shall be made within 180 days of the date as of which the new case rates were determined.

(3) If the new case rates exceed the rates in effect as of such redetermination by 10% or more, then the insurer may submit, for the Commissioner's approval, increased rates not to exceed the new case rates.

(c) The Commissioner shall disapprove submissions of proposed reduced rates pursuant to subsection (b)(2) if it is not demonstrated to him or her that they have been determined in accordance with applicable statutes and regulations.

Approved reduced rates shall become effective for the experience group within 60 days of the Commissioner's approval. The Commissioner may approve a later effective date if it is demonstrated to him or her that the approved rates cannot reasonably be implemented within 60 days of his approval.

(d) The Commissioner may disapprove proposed deviated rates if it is not demonstrated to him or her that they have been determined in accordance with applicable statutes and regulations. Upward deviated rates may become effective at any time after the Commissioner's approval or upon the 120th day following the submission of such proposals if they have not been disapproved by that day.

(e) Upward deviated rates may continue to be used where an entire experience group has transferred to a new insurer only until the next annual redetermination.

(f) No insurer shall transfer a creditor group it already insures to an experience group subject to upward deviated rates. An insurer may assign a newly insured creditor group subject to an upward deviated rate under

its prior insurer into an experience group subject to upward deviated rates only if the assignment would not result in a higher rate for the newly-insured creditor group or the existing experience group.

(g) This Section shall not preclude the Commissioner from otherwise considering proposals for rates in excess of the prima facie rates for specific creditors, creditor groups or products if it is demonstrated to him or her that the prima facie rates provide inadequate allowances for claim costs, expenses, reserves or profits or are inconsistent with other reasonable actuarial considerations given the circumstances of their particular application.

(h) Calculations for new case rates or deviated rates under Class A shall use two adjustments, before and after applying the formulas. First, adjust the earned premiums by deducting 10 cents per 1000. Apply the formulas and then add back 10 cents per 1000 to obtain the final new case or deviated rate.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
3. Amendment of subsection (h) filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.43. Reduced and Actuarially Equivalent Rates and Refund Formulas.

(a) Rates lower than the prima facie or downward deviated rates established by this Article shall be filed with the Commissioner no later than 30 days after their implementation.

(b) Rates which are actuarially equivalent to the prima facie or deviated rates established or allowed by this Article may be used upon the Commissioner's approval.

(c) Rates for coverage which do not qualify for the use of prima facie rates pursuant to § 2248.32(b) shall not exceed the actuarial equivalents of the prima facie rates established by this Article, and shall be approved by the Commissioner before their use. Such rates shall be subject to §§ 2248.37 through 2248.42.

(d) Refund formulas which are actuarially equivalent to, or more favorable to the insured than, the formulas established by this Article may be used upon the Commissioner's approval.

(e) The Commissioner may publish, by Bulletin, rates or refund formulas which he deems to be actuarially equivalent to the prima facie rates. Such rates and formulas may be used without filing with or approved by the Commissioner, but their use must be indicated on the annual experience report forms.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290 – 18292, 22458.1, 22458.2, 24458.1 and 24458.2, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.44. Annual Experience Reports.

(a) Each insurer subject to this Article shall file an annual report of its credit life and disability experience statistics with the Commissioner. Such report shall be filed no later than May 1 of the year following the calendar year reported. Each type of insurance as defined in this Article shall be reported separately on Credit Life and Disability Insurance Experience Report Forms prescribed by the Commissioner. Experience reports for insurance plans not defined in this Article shall include brief descriptions of the coverages provided. The Commissioner reserves the right to require that reports be filed in electronic media form. Each insurer shall maintain experience data on an annual basis for its business subject to this Article or to Article 6.7 of this Subchapter prior to the effective date of this Article, for at least five years.

(b) Experience statistics generated under conditions different from those assumed in § 2248.32(b), including eligibility and termination ages different than those assumed in Article 6.9, shall be reported separately.

(c) Credit insurance experience generated by business issued before the effective date of this Article shall be maintained and reported separately from experience generated under this Article.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290 – 18292, 22458.1, 22458.2, 24458.1 and 24458.2, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.45. Effective Date.

(a) This Article, effective October 1, 2001 governs the premiums charged (including refunds made for early terminations) for all individual credit insurance policies and group credit insurance certificates with effective dates on or after October 1, 2001, and the premiums charged after such date under previously issued credit insurance policies or certificates covering Open End plans of indebtedness.

(b) Prior to January 1, 2002, insurers shall not be deemed to be in violation of this Article if they are in compliance with this Article as it existed on December 31, 2000.

(c) Approved upward deviated rates in effect on September 30, 2001 shall be redetermined and refiled for approval pursuant to Section 2248.42 or be reduced on January 1, 2002 to the prima facie rates herein. The calculation of loss ratio for the refiling shall use earned premium based on the prima facie rates herein.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9, 779.13, 779.16 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Amendment of section and NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).

§ 2248.46. Severability.

If any provision of this Article or its application to any person or circumstance is held invalid for any reason, the rest of this Article and the application of such provision to any other person or circumstances shall not be affected.

NOTE: Authority cited: Section 779.21, Insurance Code. Reference: Section 779.36, Insurance Code.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).

§ 2248.47. Tables.

The rates set forth below in TABLES 1, 2 and 3 are deemed to provide, on a prima facie basis, the loss ratios established by § 2248.32(a). The formulas used to derive the rates in TABLES 2 and 3 are available from the Commissioner. Disability premiums computed in accordance with such formulas for terms of insurance not specified in TABLE 2 shall be deemed to be in compliance with this Article even though they may differ from those computed by interpolation.

TABLE 1

PRIMA FACIE MAXIMUM LIFE INSURANCE RATES
(per $1000 of insured amount per month)

Closed End	*Class(es)*	*Rate (PLR = .55)*	*Joint Multiplier*
Class A Decreasing and Level	A	$0.61	1.6230
Scheduled Decreasing and Level	B–E	$0.51	1.7451
Open End			
Line of Credit	A,B,D,E	$0.87	1.5517
Credit Card	A,B,D,E	$0.87	1.5517
Credit Union Open End	C	$0.68	1.7059
Credit Union Credit Card	C	$0.68	1.7059

TABLE 2

PRIMA FACIE DISABILITY RATES FOR CLOSED END LOANS

Sub Table A (Unsecured loans <$10,000 from "regulated lenders")

SP (*Single premium per $1000 of Initial Insured Amount*)				*Term in Months**	*MP* (*Premium per $1000 of Scheduled Remaining Payments*)			
Non–retroactive		*Retroactive*			*Non–retroactive*		*Retroactive*	
14 Day	*30 Day*	*14 Day*	*30 Day*		*14 Day*	*30 Day*	*14 Day*	*30 Day*
2.49		3.00		1	2.49		3.00	
	1.86		2.52	2		1.24		1.68
16.01	7.97	19.29	10.80	12	2.49	1.24	3.00	1.68
23.46	13.07	27.00	17.11	24	1.92	1.07	2.21	1.40
29.84	17.51	33.06	21.44	36	1.67	.98	1.85	1.20
35.32	21.29	39.30	25.26	48	1.51	.91	1.68	1.08
39.72	24.46	44.32	28.49	60	1.38	.85	1.54	.99
43.58	27.24	48.35	31.32	72	1.28	.80	1.42	.92
46.63	29.78	52.12	33.70	84	1.19	.76	1.33	.86
49.52	32.28	55.27	36.25	96	1.12	.73	1.25	.82
52.07	33.89	57.96	38.31	108	1.06	.69	1.18	.78
54.45	36.12	60.38	39.90	120	1.01	.67	1.12	.74

*Interpolate linearly for rates for durations not listed.

Sub Table B

SP (*Single premium per $1000 of Initial Insured Amount*)				*Term in Months**	*MP* (*Premium per $1000 of Scheduled Remaining Payments*)			
Non–retroactive		*Retroactive*			*Non–retroactive*		*Retroactive*	
14 Day	*30 Day*	*14 Day*	*30 Day*		*14 Day*	*30 Day*	*14 Day*	*30 Day*
2.05		2.48		1	2.05		2.48	
	2.25		3.43	2		1.50		2.29
13.18	9.64	15.94	14.72	12	2.05	1.50	2.48	2.29
19.55	15.76	22.60	20.65	24	1.60	1.29	1.85	1.69
25.02	21.09	28.24	25.91	36	1.40	1.18	1.58	1.45
29.71	25.73	33.21	30.41	48	1.27	1.10	1.42	1.30
33.67	29.64	37.42	34.54	60	1.17	1.03	1.30	1.20
36.77	33.03	41.20	37.79	72	1.08	.97	1.21	1.11
39.58	36.05	44.28	40.76	84	1.01	.92	1.13	1.04
42.00	38.46	46.87	43.77	96	.95	.87	1.06	.99
44.70	40.77	49.61	46.17	108	.91	.83	1.01	.94
46.37	43.13	51.76	48.52	120	.86	.80	.96	.90

*Interpolate linearly for rates for durations not listed.

Sub Table C (Group I)†

SP (Single premium per $1000 of Initial Insured Amount)				*Term in Months***	*MP (Premium per $1000 of Scheduled Remaining Payments)*			
Non–retroactive		*Retroactive*			*Non–retroactive*		*Retroactive*	
14 Day	*30 Day*	*14 Day*	*30 Day*		*14 Day*	*30 Day*	*14 Day*	*30 Day*
3.42		5.19		1	3.42		5.19	
	3.81		6.89	2		2.54		4.60
21.99	16.33	33.37	29.57	12	3.42	2.54	5.19	4.60
32.62	26.76	47.04	41.54	24	2.67	2.19	3.85	3.40
41.64	35.74	58.97	52.18	36	2.33	2.00	3.30	2.92
49.59	43.51	69.00	61.52	48	2.12	1.86	2.95	2.63
56.12	50.08	78.00	69.65	60	1.95	1.74	2.71	2.42
61.62	56.18	85.80	76.94	72	1.81	1.65	2.52	2.26
66.23	61.13	92.49	83.08	84	1.69	1.56	2.36	2.12
70.30	65.88	98.15	88.87	96	1.59	1.49	2.22	2.01
74.17	69.26	103.64	93.82	108	1.51	1.41	2.11	1.91
77.10	73.32	107.83	98.12	120	1.43	1.36	2.00	1.82

†For Group II, multiply Group I rates by 1.1

For Group III, multiply Group I rates by 1.3

*Interpolate linearly for rates for durations not listed.

Sub Table D

SP (Single premium per $1000 of Initial Insured Amount)				*Term in Months**	*MP (Premium per $1000 of Scheduled Remaining Payments)*			
Non–retroactive		*Retroactive*			*Non–retroactive*		*Retroactive*	
14 Day	*30 Day*	*14 Day*	*30 Day*		*14 Day*	*30 Day*	*14 Day*	*30 Day*
2.55		4.21		1	2.56		4.21	
	2.46		4.59	2		1.64		3.06
16.46	10.54	27.07	19.67	12	2.56	1.64	4.21	3.06
24.44	17.35	38.00	27.49	24	2.00	1.42	3.11	2.25
31.10	23.05	47.36	34.67	36	1.74	1.29	2.65	1.94
36.96	28.30	55.67	40.70	48	1.58	1.21	2.38	1.74
41.73	32.52	62.74	46.34	60	1.45	1.13	2.18	1.61
45.96	36.09	68.77	50.73	72	1.35	1.06	2.02	1.49
49.38	39.58	74.07	54.86	84	1.26	1.01	1.89	1.40
52.61	42.44	78.70	58.36	96	1.19	.96	1.78	1.32
55.51	44.70	82.52	61.40	108	1.13	.91	1.68	1.25
57.69	47.44	86.26	64.70	120	1.07	.88	1.60	1.20

*Interpolate linearly for rates for durations not listed.

Sub Table E

SP (Single premium per $1000 of Initial Insured Amount)				*Term in Months**	*MP (Premium per $1000 of Scheduled Remaining Payments)*			
Non–retroactive		*Retroactive*			*Non–retroactive*		*Retroactive*	
14 Day	*30 Day*	*14 Day*	*30 Day*		*14 Day*	*30 Day*	*14 Day*	*30 Day*
1.81		2.56		1	1.81		2.56	
	1.80		3.01	2		1.20		2.01
11.64	7.72	16.46	12.92	12	1.81	1.20	2.56	2.01
17.23	12.58	23.09	18.21	24	1.41	1.03	1.89	1.49
21.98	16.80	28.77	22.70	36	1.23	.94	1.61	1.27
26.20	20.58	33.92	25.26	48	1.12	.88	1.45	1.08
29.64	23.89	38.28	30.22	60	1.03	.83	1.33	1.05
32.68	26.56	41.88	33.37	72	.96	.78	1.23	.98
34.88	29.00	45.07	36.05	84	.89	.74	1.15	.92
37.14	30.95	47.75	38.46	96	.84	.70	1.08	.87
39.30	32.91	50.10	40.77	108	.80	.67	1.02	.83
40.97	34.50	52.30	42.59	120	.76	.64	.97	.79

* Interpolate linearly for rates for durations not listed.

TABLE 3

PRIMA FACIE DISABILITY RATES FOR OPEN END LOANS, ALL CLASSES

Type of Coverage	*Class of Business*	*MP (Premium per $1000 of Outstanding Principal Balance)*			
		Non–retroactive		*Retroactive*	
		14 Day	*30 Day*	*14 Day*	*30 Day*
Credit Union Open End, Group I Group II = 1.1 X (Group I) Group III = 1.3 X (Group I)	C	2.68	2.30	3.80	3.35
Line of Credit	A	1.92	1.13	2.12	1.38
	B	1.61	1.36	1.82	1.66
	C	2.68	2.30	3.80	3.35
	D	2.00	1.48	3.05	2.23
	E	1.42	1.08	1.86	1.46
Credit Card	A	1.92	1.13	2.12	1.38
	B	1.61	1.36	1.82	1.66
	C	2.68	2.30	3.80	3.35
	D	2.00	1.48	3.05	2.23
	E	1.42	1.08	1.86	1.46

TABLE 4

RATE DEVIATION CREDIBILITY TABLE

Average Number of Life Years			*Incurred Claim Count*	*Credibility Factor ("Z")*
Life	*Disability (all plans)*			
	14 Day	*30 Day*		
1	1	1	1	.00
1800	141	209	9	.25
2400	188	279	12	.30
3000	234	349	15	.35
4600	359	535	23	.45
5600	438	651	28	.50
6600	516	767	33	.55
7600	594	884	38	.60
9600	750	1116	48	.65
11600	906	1349	58	.70
14600	1141	1698	73	.75
17600	1375	2047	88	.80
20600	1609	2395	103	.85
25600	2000	2977	128	.90
30600	2391	3558	153	.95
40000	3125	4651	200	1.00

The above integers represent the lower end of the bracket for each "Z" factor.
The upper end is 1 less than the lower end for the next higher "Z" factor.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22314, 22315 and 22455, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Editorial correction amending TABLE 2, Sub Table A and Sub Table B (Register
3. Amendment of Tables 1–3, repealer of Table 5 and amendment of NOTE filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).
4. Amendment of Tables 1 and 2 and Sub Table C filed 1–9–2002; operative 1–9–2002. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2002,, No. 2).

§ 2248.48. Reporting Forms.

NOTE: Authority cited: Sections 779.21 and 779.36, Insurance Code. Reference: Sections 779.9 and 779.36, Insurance Code; Sections 18191, 18290–18292, 22458.1, 22458.2, 24458.1 and 24458.2, Financial Code; and *Credit Insurance General Agents Association v. Payne*, (1976) 16 Cal. 3d 651.

HISTORY

1. New section filed 4–14–94; operative 5–16–94. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 94, No. 15).
2. Repealer filed 10–2–2001; operative 10–1–2001. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2001, No. 40).

Article 6.9. Standard Credit Life and Credit Disability Policy Forms

§ 2249. Authority and Purpose.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code.

HISTORY

1. New Article 6.9 (Sections 2249–2249.17) filed 4–26–78; designated effective 6–1–78 (Register 78, No. 17). For history of former Article 6.9, see Registers 63, No. 15; 69, No. 9; and 69, No. 24.
2. Repealer filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).

§ 2249.1. Table of Contents.

2249.2. Forms Subject to Prior Substantive Review and Approval
2249.3. Administration of Forms
2249.4. Forms Subject to Prior to Presumptive Approval; Maintenance of File; Certificate of Compliance.
2249.5. Reservation of Right to Require Prior Approval
2249.6. Instructions for Drafting and Use
2249.7. Identification Number Chart
2249.8. List of Block Numbers for Each Identification Number—Individual Policies.
2249.9. List of Block Numbers for Each Identification Number Group Certificates.
2249.10. Schedule Blocks
2249.11. Application Blocks
2249.12. Policy and Certificate Blocks
2249.13. Notice of Proposed Insurance Blocks
2249.14. Sample Certificate (Identification Number 11).
2249.15. Effective Date
2249.16. Severability Provision.

NOTE: Authority cited: Section 779.27, Insurance Code. Reference: Section 779.27, Insurance Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
2. Amendment filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.2. Forms Subject to Prior Substantive Review and Approval.

The following credit life and/or credit disability insurance forms shall be submitted to the Commissioner for his prior substantive review and approval following the procedures established by Sections 2201 through 2217 of this Subchapter.

(a) Standard forms for use by an insurer which has not actively transacted a substantial volume of credit life and/or disability insurance business in the State of California for a year prior to the date upon which the

forms are proposed to be issued, unless and until such prior substantive review is expressly waived by the Commissioner in writing.

(b) Forms intended for use in lieu of the standard forms established by this Article. Cover letters for submission of such forms shall prominently state that the forms are to be issued in lieu of standard forms.

(c) Forms or provisions in forms not otherwise subject to this Section which provide coverage in addition to or different from the coverage provided by the forms established by this Article.

(d) Forms described in subsections (b) and (c) of this Section shall be drafted in text designed to be readily understood and interpreted by the persons insured thereunder and shall be based, to the extent possible, upon the standard forms established. Non–standard language in such forms shall be "highlighted" when they are submitted for review. Each such form shall use the Identification Number of the standard form upon which it was based, with "NON STD" added as a prefix or suffix.

The Commissioner shall disapprove such a form:

(1) If it would produce experience statistics which would not be readily usable in developing prima facie premium rates.

(2) If it uses atypical language or format and would, therefore, hinder consumer education.

(3) If it is not established to his satisfaction that its use will be more beneficial to the citizens of this State than the use of standard forms;

(4) It does not comply with any other applicable statute or regulation.

(e) The Commissioner waives the refiling of previously–approved forms described in Subsections (b) and (c) of this Section that are changed solely to reflect the 2008 amendments of this Article.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 779.8, 779.9, 779.12a and 779.27, Insurance Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
2. Amendment of first paragraph and subsection (a) and repealer and new NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).
3. New subsection (e) filed 5–27–2008; operative 6–26–2008 (Register 2008, No. 22).

§ 2249.3. Administration of Forms.

In addition to all other applicable statutes and regulations, the following rules shall be followed in administering the forms subject to this Article.

(a) Where a new policy or certificate is issued because of the renewal or refinancing of an indebtedness previously insured, any time which had accumulated toward the satisfaction of any waiting or elimination period under the preceding coverage shall be credited toward the satisfaction of such period under the new policy or certificate. Credit shall apply to the extent that the type of coverage is the same under the old and new policies or certificates and to the extent of the indebtedness carried over from the old indebtedness. Any eligibility requirement (such as "active–at–work") which was satisfied under the preceding coverage shall be waived under the new coverage to the extent of the type and amount of coverage carried over from the old policy or certificate.

(b) If a closed–end loan terminates by pre–payment, renewal or refinancing during a period of covered disability, disability benefits shall continue to be paid as if the loan had not been prematurely terminated unless the insured requests cancellation.

(c) Termination of a group policy shall not affect the coverage provided by single premium certificates issued thereunder.

(d) A monthly premium certificate shall not be terminated due to termination of the group policy on less than 31 days advance notice given to the borrower, except where there is immediate replacement of coverage.

(e) Coverage under a certificate for which premium is collected on other than a single premium or monthly premium basis shall not terminate due to termination of the master policy before the end of the period for which premium has been paid. Coverage under such a certificate shall be continued for the next premium period, subject to payment of the premium to the insurer, either directly or through the creditor, if notice of termination is not given to the borrower at least 31 days before the end of the period for which premium was paid, except where there is immediate replacement of coverage.

(f) A copy of the Borrower's Application shall be attached when a Notice of Proposed Insurance is delivered.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 779.1, 779.5, 779.7, 779.9 and 779.27, Insurance Code.

HISTORY

1. Repealer and new section filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).

§ 2249.4. Forms Subject to Presumptive Approval; Maintenance of File; Certificate of Compliance.

Unless subject to Section 2249.2 of this Article, standard forms which are drafted in accordance with this Article and forms of group master policies which provide coverage reflected in standard certificate forms established by this Article shall be deemed to be approved without filing after June 1, 1979. Forms subject to this Article shall maintained by the insurer in a file until 3 years following the date upon which coverage last terminated under each form. Such file shall be reasonably accessible to the public and insurers shall respond promptly to requests for copies of the forms contained therein. A reasonable fee may be charged for supplying such copies.

Commencing with the Annual Statement for the year of 1979, each insurer issuing forms subject to this Article shall file a Certificate of Compliance with its Annual Statement for each year in which such forms are issued. Such certificate shall be captioned "Certificate of Compliance (Credit Life and/or Credit Disability Forms)" and shall list the form numbers of the forms issued in that year. Form numbers of group and individual policies and group certificates shall be accompanied by the Identification Numbers for the coverage provided except for those forms approved under Subsections (b) and (c) of Section 2249.2 of this Article. The Certificate of Compliance shall be executed by an authorized officer of the insurer who shall state that, to the best of his or her knowledge, information and belief, the listed forms were the only credit life and/ or disability forms issued by the insurer in that Annual Statement year and that such forms comply in all respects with this Article.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 779.8, 779.9, 779.10, 779.12a, 779.18, 779.27 and 900, Insurance Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).

§ 2249.5. Reservation of Right to Require Prior Approval.

The Commissioner reserves the right to require, upon written notice to an insurer, that forms otherwise subject to Section 2249.4 of this Article, be filed with and approved by him before they are issued or delivered.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 779.8, 779.9, 779.10, 779.12a, 7791.8 and 779.27, Insurance Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).

§ 2249.6. Instructions for Drafting and Use.

(a) Generally. This Article does not supersede any other statutes or regulations pertaining to the use of particular types of forms in certain circumstances. (For example, only group forms may be used by credit unions.)

The standard forms set forth below reflect 30 day elimination period coverage, but any other permissible coverage may be substituted. The designation of the coverage may be preprinted or filled in later. Terms, such as "borrower", "creditor", "loan" and "advance", appearing in the standard forms may be varied, provided that such variance is required by the circumstances of use and that the substituted terms are consistent and not misleading. Age "66" may be substituted for "65" where it appears in the standard forms. Forms with ages other than those set forth in these regulations must be submitted for approval on a non–standard basis pursuant to § 2249.2(d).

Standard and non–standard forms shall be printed in type which complies with the standard of Insurance Code Section 10320(d).

Where debtors may elect among several coverage, insurers may use forms which provide all the coverage offered. However, forms showing coverage which are not available to the debtors to be covered may not be used.

(b) Drafting Instructions for Individual Policies and Group Certificates. Standard policy and certificate forms shall be assembled from the blocks of text set forth in Sections 2249.10 through 2249.12 of this Article as follows:

(1) Select the appropriate Identification Number for the desired coverage from the Identification Number Chart in Section 2249.7 of this Article. (Note that the Identification Number refers to the coverage provided rather than to the type of document.)

(2) Depending upon whether an individual policy or a group certificate is being drafted, enter the appropriate List of Block Numbers for Each Identification Number (Section 2249.8 or 2249.9 of this Article) with the selected Identification Number. The sequence of text blocks is indicated by the block numbers following each Identification Number.

(3) An illustrative sample Identification Number 11 Certificate is set forth in Section 2249.14 of this Article.

(c) Schedules. Schedule blocks may appear in any sequence which is not misleading or confusing. The reference to maximum benefits in the schedule may be deleted if benefits are not subject to a maximum. Additional schedule items may be added to the schedule if the net effect of such additions is not confusing or misleading. Schedule blocks specified for each policy or certificate must not be deleted. The insurer must be able to identify the seller of any particular policy or certificate by means of the designation "Source Code." Every policy or certificate must indicate the rate class by means of the designation of "Class of Business."

(d) Applications. The following text may be inserted in applications:

"I want insurance._____

I do not want insurance._____"

"You understand you do not have to buy this insurance to get your loan approved."

The medical application, Application Block AP 20, or any portion thereof, may be used with any form. The numbered paragraphs in the non–medical application for the type of coverage being applied for should be substituted for paragraphs 2 through 4 in the subscription agreement AP 20 when they differ from the AP 20 text. For applications to be used with ID forms 18 through 22 and 25 through 29, also replace the sentence, "You are applying for the credit insurance marked above.", in AP 20, with the following: "You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Retain the second standard sentence, "You should understand that . . . cancel your insurance protection." The medical application may be formatted so that questions apply separately to co–borrowers.

"Date of Birth" may be substituted for "age" in the signature blanks in the applications.

The phrase "(Refer to "Total Disabilities Not Covered" in your policy for details.)" shall be changed to "(Refer to the Notice of Proposed Insurance for details.)" in applications which are used with Notice of Proposed Insurance.

(e) Policy and Certificate Blocks. The sequence of these blocks must not vary from that set forth in Sections 2249.8 and 2249.9 of this Article.

Policies or certificates which include disability coverage and which are not printed on the same document as the application shall contain the following text on the front page:

"DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS. (Refer to "Total Disabilities Not Covered" in this policy for details.)"

(f) Dividend Provision. The following text may be inserted in an appropriate location where required by law:

"Our Board of Directors will determine annually whether a dividend will be paid on this policy."

(g) Block Numbers. Block numbers shall not appear on forms drafted in accordance with this Article.

(h) Notices of Proposed Insurance. The standard Notices of Proposed Insurance shall be assembled from the Notice of Proposed Insurance blocks set forth in Section 2249.13 in the same manner as the standard policies and certificates. The Notice of Proposed Insurance block sequences are listed following "NOPI:" in Section 2249.9. (Notices of Proposed insurance are the same for individual policies and group certificates.) The wording "policy or certificate" may be changed to refer only to "policy" or only to "certificate" if desired.

(i) Form Numbers and Identification Numbers. All forms drafted in accordance with this Article shall be identified by a form number in the lower left corner of the front of the document. Such forms shall indicate the Identification Number of the coverage provided in the lower right corner of the page upon which the form number appears, except for those forms which do not reflect a specific coverage or coverage.

(j) Group Master Policies. Group master policies may be brought into conformity with this Article by adding an amendatory endorsement to the effect of "Policy _____ is hereby amended to provide coverage exactly as described in Certificate(s) _____ attached."

(k) Partial Payoff. Forms covering only a portion of a loan which exceeds the insurer's maximum benefit levels must include the paragraph captioned "Partial Payoff" as set out below. The paragraph referring to life insurance may be eliminated if only disability insurance is provided, and the paragraph referring to disability insurance may be eliminated if only life insurance is provided. The "Partial Payoff" paragraph must be the final paragraph in the section titled "WHAT WE WON'T PAY."

Partial Payoff

If the Original Amount of Life Insurance shown in the Schedule is less than the original amount of your debt, the life insurance benefit may not completely pay off your debt. See the paragraph titled "Amount of Life Insurance" to calculate the partial payoff.

If the Monthly Total Disability Benefit shown in the Schedule is less than your Monthly Loan Payment, you will have to pay the creditor the difference each month to keep your loan from being delinquent.

In addition, the face page of the policy or certificate must have a prominent overprint or provision reading: "Warning: This insurance may not be enough to completely pay off your loan." Also, "We will not pay more than the Maximum Amount of Life Insurance in the Schedule," shall be added to the end of the Amount of Life Insurance provision, as appropriate.

The "Partial Payoff" provision may not be used with Identification Numbers 6 through 10.

Forms which use any other system for partial coverage must be submitted for approval pursuant to Section 2249.2 of this Article.

(*l*) Credit Union Open End and Credit Card Coverages.

(1) Forms providing life insurance coverage on Credit Union Open End loans, as defined in §2248.31, may use Policy and Certificate Block PC 3 in lieu of Block PE 3.

(2) Forms providing disability coverage on "credit cards" subject to Ins. C. §779.30(f) shall use Policy and Certificate Block PJ 1 in lieu of Block PJ 2. Notices of Proposed Insurance, if any, shall use Notice of Proposed Insurance Block C–1 in lieu of Block C–3.

(m) "Critical period" disability coverage may be provided by substituting Text Block PF 4 for Text Block PF 1 from Section 2249.12 and adding Schedule Block SC 37 from Section 2249.10. Where such coverage is provided, a Partial Payoff paragraph and warning overprint shall

be used pursuant to subsection (k). The Partial Payoff disability paragraph shall be replaced with:

"If the remaining term of your loan exceeds the Maximum Disability Benefit Period in the Schedule when you become disabled, you will have to resume payments to the Creditor after the Maximum Disability Benefit Period ends."

If a Notice of Proposed Insurance is used, Notice of Proposed Insurance Block C–4 shall be substituted for Notice of Proposed Insurance Block C–1.

(n) Joint disability coverage may be provided for as follows:

(1) Add the sentence, "If you are insured for joint disability, only one Monthly Total Disability Benefit will be paid for any month in which you are both disabled," to the end of the appropriate standard Total Disability Insurance Benefit text block. If a Notice of Proposed Insurance is used, also insert the quoted sentence immediately before "We won't pay the claim if your disability:", in the Notice provision commencing with, "If you are insured for total disability . . . ."

(2) Delete the sentence, "Only the Primary Borrower is eligible for disability insurance," from the application.

(3) For single premium forms, use Schedule Block SC 38 in place of Schedule Block SC 15; for monthly premium forms, use Schedule Blocks SC 39 and SC 40 in place of Schedule Blocks SC 29 and SC 30.

(o) Standard language is not provided in these regulations for:

(1) Life insurance subject to pre–existing conditions limitations. Such coverages must be provided by non–standard forms approved by the Commissioner pursuant to § 2249.2.

(2) Life and health insurance guarantee association summary documents required by Insurance Code § 1067.17. Such documents are exempt from filing under these regulations.

(3) Notices of information practices which may be required by Ins. C. § 791.04. Such notices are exempt from filing under these regulations.

(p) Consumer Contact Notices. Either the reference to the Creditor Beneficiary or the reference to the insurer may be omitted from the Department of Insurance consumer contact notice in Policy and Certificate Blocks PA 1 through PA 4 and in Notice of Proposed Insurance Blocks D–1 and D–2. A Creditor Beneficiary shall be referred to in the consumer contact notice if it is a licensed insurance agent that delivers individual policies or certificates to debtors. If a Creditor Beneficiary is referred to in the consumer contact notice, then its address and telephone number must appear in the Creditor Beneficiary Schedule Block or be included in the consumer contact notice.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 510, 779.4 779.10, 779.12a, 779.14, 779.18, 779.27–779.31, 10113, 10113.5, 10203.5, 10203.55, 10207, 10208, 10209, 10270.505, 10270.94 and 10291, Insurance Code; and Sections 18290–18292, 22314, 22315 and 22455, Financial Code.

HISTORY

1. New subsection (1) filed 12–29–78; designated effective 4–1–79 (Register 79, No. 2).
2. Amendment of subsections (a),(d),(h),(k) and (1), and new subsection (m) filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
3. Amendment of subsections (d) and (e) filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
4. Editorial correction of subsection (d) (Register 2006, No. 32).
5. Editorial correction of subsection (c) (Register 2006, No. 40).
6. Amendment of section and repealer and new NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.7. Identification Number Chart.

			Life						
I.D. #	*Single Premium*	*Monthly Premium*	*Net Balance*	*Level Amount*	*Open End*	*Closed End*	*Single Life*	*Joint Life*	*Disability*
I.D. #s 1 through 5 repealed									
"Class A" business (See §2248.31)									
6	X		X			X	X	X	X
7	X		X			X	X	X	
8	X		X			X	X		X
9	X		X			X	X		
10	X					X			X
Basic Coverage									
11	X		X			X	X	X	X
12	X		X			X	X	X	
13	X		X			X	X		X
14	X		X			X	X		
15	X					X			X
Level Life									
16	X			X		X	X	X	
17	X			X		X	X	X	
Line of Credit, Credit Union Open–end and Credit Card									
18		X	X		X		X	X	X
19		X	X		X		X		X
20		X			X				X
21		X	X		X		X	X	
22		X	X		X		X		

I.D. #	*Single Premium*	*Monthly Premium*	*Net Balance*	*Level Amount*	*Open End*	*Closed End*	*Single Life*	*Joint Life*	*Disability*
Monthly Premium, Closed–End									
25		X	X			X	X	X	X
26		X	X			X	X	X	
27		X	X			X	X		X
28		X	X			X	X		
29		X				X			X
Agricultural									
30	X			X		X	X	X	X
31	X			X		X	X	X	
32	X			X		X	X		X
33	X			X		X	X		
34	X					X			X

NOTE: Authority cited: Section 779.21 and 779.27, Insurance Code. Reference: Section 779.4, Insurance Code; and Sections 18290–18292, 22314, 22315 and 22455, Financial Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
2. Amendment filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
3. Amendment of section and repealer and new NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.8. List of Block Numbers for Each Identification Number—Individual Policies.

#6—MH 1; SC 1 though SC 7; SC 9; SC 10; SC 12; SC 14 through SC 16; SC 20 through SC 22; AP 5; PA 1; PB 1; PC 1; PD 1; PE 2; PF 1; PG 1; PH 1; PI 1; PJ 1; PK 2; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#7—MH 1; SC 1 through SC 7; SC 9; SC 10; SC 14; SC 18; SC 20 through SC 22; AP 6; PA 1; PB 1; PC 1; PD 1; PE 2; PH 1; PI 1; PK 2; PL 1; PN 1; PO 1; PQ 1.

#8—MH 1; SC 1; SC 3 through SC 7; SC 9; SC 10; SC 12; SC 19; SC 15 through SC 18; SC 20 through SC 22; AP 7; PA 1; PB 1; PC 1; PE 2; PF 1; PG 1; PH 2; PI 3; PJ 1; PK 2; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#9—MH 1; SC 1; SC 3 through SC 7; SC 9; SC 10; SC 19 through SC 22, AP 8; PA 1; PB 1; PC 1; PE 2; PH 2; PI 3; PK 2; PL 1; PN 1; PO 1; PQ 1.

#10—MH 1; SC 1; SC 3 through SC 7; SC 9; SC 12; SC 15; SC 20 through SC 22; AP 3; PA 1; PB 1; PC 2; PE 6; PF 1; PG 1; PH 2; PJ 1; PK 2; PL 1; PM 1; PO 1; PP 1; PQ 1.

#11—MH 1; SC 1 through SC 18; AP 1; PA 1; PB 1; PC 1; PD 1; PE 4; PF 1; PG 1; PH 1; PI 1; PJ 1; PK 1; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#12—MH 1; SC 1 through SC 11; SC 14; SC 18; AP 2; PA 1; PB 1; PC 1; PD 1; PE 4; PH 1; PI 1; PK 1; PL 1; PN 1; PO 1; PQ 1.

#13—MH 1; SC 1; SC 3 through SC 13; SC 15; SC 19; SC 17; SC 18; AP 3; PA 1; PB 1; PC 1; PE 4; PF 1; PG 1; PH 2; PI 3; PJ 1; PK 1; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#14—MH 1; SC 1; SC 3 through SC 12; SC 18; SC 19; AP 4; PA 1; PB 1; PC 1; PE 4; PH 2; PI 3; PK 1; PL 1; PN 1; PO 1; PQ 1.

#15—MH 1; SC 1, SC 3 through SC 6; SC 8; SC 9; SC 11; SC 12; SC 13; SC 15; SC 17; AP 3; PA 1; PB 1; PC 2; PF 1; PG 1; PH 2; PJ 1; PK 1; PL 1; PM 1; PO 1; PP 1; PQ 1.

#16—MH 1; SC 1 through SC 9; SC 11; SC 18; SC 23; SC 24; AP 2; PA 1; PB 1; PC 1; PD 1; PE 5; PH 1; PI 1; PK 3; PL 1; PN 1; PO 1; PQ 1.

#17—MH 1; SC 1; SC 3 through SC 9; SC 11; SC 18; SC 23; SC 25; AP 4; PA 1; PB 1; PC 1; PE 5; PH 2; PI 3; PK 3; PL 1; PN 1; PO 1; PQ 1.

#18—MH 1; SC 1; SC 2 through SC 7; SC 9; SC 17; SC 18; SC 29; SC 30; AP 10; PA 4; PB 1; PC 1; PD 1; PE 3; PF 3; PG 1; PH 1; PI 2; PJ 2; PK 5; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#19—MH 1; SC 1; SC 3 through SC 7; SC 9; SC 17; SC 18; SC 33; SC 34; AP 18; PA 4; PB 1; PC 1; PE 3; PF 3; PG 1; PH 2; PI 4; PJ 2; PK 5; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#20—MH 1; SC 1; SC 3 through SC 6; SC 9; SC 15; SC 17; SC 36; AP 19; PA 4; PB 1; PC 2; PF 3; PG 1; PH 2; PJ 2; PK 5; PL 1; PM 1; PO 1; PP 1; PQ 1.

#21—MH 1; SC 1 through SC 7; SC 9; SC 18; SC 31; SC 32; AP 11; PA 4; PB 1; PC 1; PD 1; PE 3; PH 1; PI 2; PK 5; PL 1; PN 1; PO 1; PQ 1.

#22—MH 1; SC 1; SC 3 through SC 7; SC 9; SC 18; SC 35; AP 12; PA 4; PB 1; PC 1; PE 3; PH 2; PI 4; PK 5; PL 1; PN 1; PO 1; PQ 1.

#25—MH 1; SC 1 through SC 13; SC 17; SC 18; SC 29; SC 30; SC 16; AP 21; PA 4; PB 1; PC 1; PD 1; PE 4; PF 1; PG 1; PH 1; PI 1; PJ 1; PK 7; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#26—MH 1; SC 1 through SC 11; SC 18; SC 31; SC 32; SC 16; AP 22; PA 4; PB 1; PC 1; PD 1; PE 4; PH 1; PI 1; PK 7; PL 1; PN 1; PO 1; PQ 1.

#27—MH 1; SC 1; SC 3 through SC 13; SC 17; SC 18; SC 33; SC 34; SC 16; AP 23; PA 4; PB 1; PC 1; PE 4; PF 1; PG 1; PH 2; PI 3; PJ 1; PK 7; PL 1; PM 1; PN 1; PO 1; PP 1; PQ 1.

#28—MH 1; SC 1; SC 3 through SC 11; SC 18; SC 35; SC 16; AP 24; PA 4; PB 1; PC 1; PE 4; PH 2; PI 3; PK 7; PL 1; PN 1; PO 1; PQ 1.

#29—MH 1; SC 1; SC 3 through SC 6; SC 8; SC 9; SC 11; SC 12; S 13; SC 17; SC 36; SC 16; AP 25; PA 4; PB 1; PC 2; PF 1; PG 1; PH 2; PJ 1; PK 7; PL 1; PM 1; PO 1; PP 1; PQ 1.

#30—MH 1; SC 1 through SC 9; SC 1 1; SC 13; SC 15; SC 24; SC 16; SC 23; AP 17; PA 1; PB 1; PC 1; PD 1; PE 5; PF 1; PG 1; PH 3; PI 1; PJ 1; PK 8; PL 3; PM 1; PN 1; PO 1; PP 1; PQ 1.

#31—MH 1; SC 1 through SC 9; SC 11; SC 24; AP 13; PA 1; PB 1; PC 1; PD 1; PE 5; PH 3; PI 1; PK 3; PL 3; PN 1; PO 1; PQ 1.

#32—MH 1; SC 1; SC 3 through SC 13; SC 19; SC 15; SC 16; AP 14; PA 1; PB 1; PC 1; PE 5; PF 1; PG 1; PH 4; PI 3; PJ 1; PK 8; PL 3; PM 1; PN 1; PO 1; PP 1; PQ 1.

#33—MH 1; SC 1; SC 3 through SC 9; SC 11; SC 23; SC 25; AP 15; PA 1; PB 1; PC 1; PE 5; PH 4; PI 3; PK 3; PL 3; PN 1; PO 1; PQ 1.

#34—MH 1; SC 1; SC 3 through SC 9; SC 11 through SC 13; SC 15; AP 16; PA 1; PB 1; PC 2; PF 1; PG 1; PH 4; PJ 1; PK 8; PL 3; PM 1; PO 1; PP 1; PQ 1.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Section 779.4, Insurance Code; and Sections 18290–18292, 22314, 22315 and 22455, Financial Code.

HISTORY

1. Amendment of paragraphs #18, #19, and #20 filed 12–29–78; designated effective 4–1–79 and for technical reasons, printed in Register 78, No. 52.
2. Amendment of paragraphs #10, #13, #16, #17, #22, and #24 through #34, filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
3. Amendment of paragraphs #6, #8, #10, #18–#20, #25–#29 and repealer of paragraphs #23 and #24 filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
4. Amendment of section and repealer and new NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.9. List of Block Numbers for Each Identification Number—Group Certificates.

#6—MH 1; SC 1; SC 2; SC 4 through SC 7; SC 9; SC 10; SC 12; SC 14 through SC 16; SC 20 through SC 22; SC 26; SC 27; AP 5; PA 3; PB 1; PC 1; PD 1; PE 2; PF 1; PG 1; PH 1; PI 1; PJ 1; PK 2; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–3; C–1; D–2.

#7—MH 1; SC 1; SC 2; SC 4 through SC 7; SC 9; SC 10; SC 14; SC 18; SC 20 through SC 22; SC 26; SC 27; AP 6; PA 3; PB 1; PC 1; PD 1; PE 2; PH 1; PI 1; PK 2; PL 2; PN 1; NOPI: A–2; B–3; D–2.

#8—MH 1; SC 1; SC 4 through SC 7; SC 9; SC 10; SC 12; SC 19; SC 15 through SC 18; SC 20 through SC 22; SC 26; SC 27; AP 7; PA 3; PB 1; PC 1; PE 2; PF 1; PG 1; PH 2; PI 3; PJ 1; PK 2; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–4; C–1; D–2.

#9—MH 1; SC 1; SC 4 through SC 7; SC 9; SC 10; SC 19 through SC 22; SC 26; SC 27; AP 8; PA 3; PB 1; PC 1; PE 2; PH 2; PI 3; PK 2; PL 2; PN 1; NOPI: A–2; B–4; D–2.

#10—MH 1; SC 1; SC 4 through SC 7; SC 9; SC 12; SC 15; SC 20 through SC 22; SC 26; SC 27; AP 3; PA 3; PB 1; PC 2; PE 6; PF 1; PG 1; PH 2; PJ 1; PK 2; PL 2; PM 1; PP 1. NOPI: A–3; C–1; D–2.

#11—MH 1; SC 1; SC 2; SC 4 through SC 18; SC 26; SC 27; AP 1; PA 3; PB 1; PC 1; PD 1; PE 4; PF 1; PG 1; PH 1; PI 1; PJ 1; PK 1; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–5; C–1; D–1.

#12—MH 1; SC 1; SC 2; SC 4 through SC 11; SC 14; SC 18; SC 26; SC 27; AP 2; PA 3; PB 1; PC 1; PD 1; PE 4; PH 1; PI 1; PK 1; PL 2; PN 1; NOPI: A–2; B–5; D–1.

#13—MH 1; SC 1; SC 4 through SC 13; SC 15; SC 19; SC 17; SC 18; SC 26; SC 27; AP 3; PA 3; PB 1; PC 1; PE 4; PF 1; PG 1; PH 2; PI 3; PJ 1; PK 1; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–6; C–1; D–1.

#14—MH 1; SC 1; SC 4 through SC 12; SC 18; SC 19; SC 26; SC 27; AP 4; PA 3; PB 1; PC 1; PE 4; PH 2; PI 3; PK 1; PL 2; PN 1; NOPI: A–2; B–6; D–1.

#15—MH 1; SC 1; SC 4 through SC 6; SC 8; SC 9; SC 11; SC 12; SC 13; SC 15; SC 17; SC 26; SC 27; AP 3; PA 3; PB 1; PC 2; PF 1; PG 1; PH 2; PJ 1; PK 1; PL 2; PM 1; PP 1. NOPI: A–3; C–1; D–1.

#16—MH 1; SC 1; SC 2; SC 4 through SC 9; SC 11; SC 18; SC 23; SC 24; SC 26; SC 27; AP 2; PA 3; PB 1; PC 1; PD 1; PE 5; PH 1; PI 1; PK 3; PL 2; PN 1; NOPI: A–2; B–7; D–1.

#17—MH 1; SC 1; SC 4 through SC 9; SC 11; SC 18; SC 23; SC 25 through SC 27; AP 4; PA 3; PB 1; PC 1; PE 5; PH 2; PI 3; PK 3; PL 2; PN 1; NOPI: A–2; B–8; D–1.

#18—MH 1; SC 1; SC 2; SC 4 through SC 7; SC 9; SC 17; SC 18; SC 26; SC 27; SC 29; SC 30; AP 10; PA 2; PB 1; PC 1; PD 1; PE 3; PF 3; PG 1; PH 1; PI 2; PJ 2; PK 4; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–9; C–3; D–3.

#19—H 1; SC 1; SC 4 through SC 7; SC 9; SC 17; SC 18; SC 26; SC 27; SC 33; SC 34; AP 18; PA 2; PB 1; PC 1; PE 3; PF 3; PG 1; PH 2; PI 4; PJ 2; PK 4; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–10; C–3; D–3.

#20—MH 1; SC 1; SC 4 through SC 6; SC 9; SC 15; SC 17; SC 26; SC 27; SC 36; AP 19; PA 2; PB 1; PC 2; PF 3; PG 1; PH 2; PJ 2; PK 4; PL 2; PM 1; PP 1. NOPI: A–3; C–3; D–3.

#21—MH 1; SC 1; SC 2; SC 4 through SC 7; SC 9; SC 18; SC 26; SC 27; SC 31; SC 32; AP 11; PA 2; PB 1; PC 1; PD 1; PE 3; PH 1; PI 2; PK 4; PL 2; PN 1; NOPI: A–2; B–9; D–3.

#22—MH 1; SC 1; SC 4 through SC 7; SC 9; SC 18; SC 26; SC 27; SC 35; AP 12; PA 2; PB 1; PC 1; PE 3; PH 2; PI 4; PK 4; PL 2; PN 1; NOPI: A–2; B–10; D–3.

#25—MH 1; SC 1; SC 2; SC 4 through SC 13; SC 17; SC 18; SC 26; SC 27, SC 29; SC 30; SC 16; AP 21; PA 2; PB 1; PC 1; PD 1; PE 4; PF 1; PG 1; PH 1; PI 1; PJ 1; PK 6; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–5; C–1; D–3.

#26—MH 1; SC 1; SC 2; SC 4 through SC 11; SC 18; SC 26; SC 27; SC 31; SC 32; SC 16; AP 22; PA 2; PB 1; PC 1; PD 1; PE 4; PH 1; PI 1; PK 6; PL 2; PN 1; NOPI A–2; B–5; D–3.

#27—MH 1; SC 1; SC 4 through SC 13; SC 17; SC 18; SC 26; SC 27; SC 33; SC 34; SC 16; AP 23; PA 2; PB 1; PC 1; PE 4; PF 1; PG 1; PH 2; PI 3; PJ 1; PK 6; PL 2; PM 1; PN 1; PP 1. NOPI: A–1; B–6; C–1; D–3.

#28—MH 1; SC 1; SC 4 through SC 11, SC 18; SC 26; SC 27; SC 35; SC 16; AP 24; PA 2; PB 1; PC 1; PE 4; PH 2; PI 3; PK 6; PL 2; PN 1; NOPI: A 2; B–6; D–3.

29—MH 1; SC 1; SC 4 through SC 6; SC 8; SC 9; SC 11 through SC 13; SC 17; SC 26; SC 27; SC 36; SC 16; AP 25; PA 2; PB 1; PC 2; PF 1; PG 1; PH 2; PJ 1; PK 6; PL 2; PM 1; PP 1. NOPI: A–3; C–1; D–3.

#30—MH 1; SC 1; SC 2; SC 4 through SC 9; SC 11; SC 13; SC 15; SC 24; SC 16; SC 23; SC 26; SC 27; AP 17; PA 3; PB 1; PC 1; PD 1; PE 5; PF 1; PG 1; PH 3; PI 1; PJ 1; PK 8; PL 4; PM 1; PN 1; PP 1. NOPI: A–1; B–7; C–1; D–1.

#31—MH 1; SC 1; SC 2; SC 4 through SC 9; SC 11; SC 24; SC 26; SC 27; AP 13; PA 3; PB 1; PC 1; PD 1; PE 5; PH 3; PI 1; PK 3; PL 4; PN 1; NOPI: A–2; B–7; D–1.

#32—MH 1; SC 1; SC 4 through SC 13; SC 19; SC 15; SC 16; SC 26; SC 27; AP 14; PA 3; PB 1, PC 1; PE 5; PF 1; PG 1; PH 4; PI 3; PJ 1; PK 8; PL 4; PM 1; PN 1; PP 1. NOPI: A–1; B–8; C–1; D–1.

#33—MH 1; SC 1; SC 4 through SC 9; SC 11; SC 23; SC 25; SC 26; SC 27; AP 15; PA 3; PB 1; PC 1; PE 5; PH 4; PI 3; PK 3; PL 4; PN 1; NOPI: A–2; B–8; D–1.

#34—MH 1; SC 1; SC 4 through SC 9; SC 11 through SC 13; SC 15; SC 26; SC 27; AP 16; PA 3; PB 1; PC 2; PF 1; PG 1; PH 4; PJ 1; PK 8; PL 4; PM 1; PP 1. NOPI: A–3; C–1; D–1.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Section 779.4, Insurance Code; and Sections 18290–18292, 22314, 22315 and 22455, Financial Code.

HISTORY

1. Amendment of paragraphs #18, #19, and #20 filed 12–29–78; designated effective 4–1–79 and for technical reasons printed in Register 78, No. 52.
2. Amendment of paragraphs #1 through #34 filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
3. Amendment of paragraphs #6, #8, #10, #21, #22 and repealer of paragraphs #23 and #24 filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
4. Amendment of section and repealer and new NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).
5. Amendment of paragraph #11 filed 5–27–2008; operative 6–26–2008 (Register 2008, No. 22).

§ 2249.10. Schedule Blocks.

MH1

Insurers Name and Complete Address
Called We or Us

SCHEDULE

SC1	Primary Borrower, called you, and Address
SC2	Co–Borrower, also called you
SC3	Policy Number
SC4	Source Code
SC5	Creditor Beneficiary and Insurance Agent's License No.
SC6	Class of Business
SC7	Secondary Beneficiary
SC8	Term of Insurance
SC9	Effective Date
SC10	Original Amount of Life Insurance
SC11	Scheduled Expiration Date
SC12	Monthly Loan Payment
SC13	Monthly Total Disability Benefit

SC14 Decreasing Life: Single ( ) joint ( ) Premium:
SC15 Disability: 30–day Elimination Period Premium:
SC16 Total Premium:SC17 Maximum Monthly Disability Benefit:
SC18 Maximum Amount of Life Insurance:
SC19 Decreasing Single Life Premium:
SC20 Number of Monthly Installments
SC21 First Installment Due Date
SC22 Final Installment Due Date
SC23 Amount of Level Life Insurance:
SC24 Level Life: Single ( ) joint ( ) Premium:
SC25 Level Life Single Premium;
SC26 Group Policy Number
SC27 Certificate Number
SC28 Date of Issue of this Certificate
SC29 Credit Insurance Applied for: ____ Single Life____Joint Life ____30 Day Elimination Disability
SC30 Monthly Premium per $100 of insured debt: Single Life $____ Joint Life $____ Disability $____
SC31 Credit Insurance Applied for:____Single Life ____Joint Life
SC32 Monthly Premium per $100 of insured debt: Single Life $____Joint Life $____
SC33 Credit Insurance Applied for:____Single Life____30 Day Elimination Disability
SC34 Monthly Premium per $100 of insured debt: Single Life $____Disability $____
SC35 Monthly Life Insurance Premium per $100 of insured debt: $____
SC36 Monthly Disability Premium per $100 of insured debt $____
SC37 Maximum Disability Benefit Period
SC 38 Disability, 30–day Elimination Period: Single ( ) Joint ( ) Premium:
SC 39 Credit Insurance Applied for: Life: Single ( ) Joint ( ); 30 Day Elimination Disability: Single ( ) Joint ( )
SC 40 Monthly Premium per $100 of insured debt: Life: Single $____ , Joint $____ ; Disability: Single $____ , Joint $____

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 779.4, 779.6 and 1758.99, Insurance Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
2. Amendment of section and NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.11. Application Blocks.

AP 1

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.
2. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.
3. Only the Primary Borrower is eligible for disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

Co–Borrower Age

AP 2

APPLICATION OF BORROWER

You are applying for credit insurance marked above. Your signature below means that you agree that you are not eligible for insurance if you have reached your 65th birthday.

Date Primary Borrower Age

Co–Borrower Age

AP 3

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.
2. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.
3. Only the Primary Borrower is eligible for life or disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to Total Disabilities Not Covered" in your certificate for Details)

Date Primary Borrower Age

AP 4

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that:

1. You are not eligible for insurance if you have reached your 65th birthday.
2. Your co–borrower is not eligible for life or disability insurance.

Date Primary Borrower Age

AP 5

APPLICATION FOR CREDIT INSURANCE

You are applying for the insurance marked above. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.
2. You do not have to buy any life insurance to be eligible for disability coverage, or vice versa.
3. You are eligible for disability coverage only if you are working for wages or profit, for 30 hours a week or more, on the Effective Date.
4. Only the Primary Borrower is eligible for disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

Co–Borrower Age

THIS INSURANCE MAY BE ISSUED ONLY TO COVER BORROWERS WHO HAVE A LOAN UNDER THE INDUSTRIAL LOAN LAW OR THE CALIFORNIA FINANCE LENDERS LAW.

AP 6

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that you are not eligible for insurance if you have reached your 65th birthday.

Date Primary Borrower Age

Co–Borrower Age

THIS INSURANCE MAY BE ISSUED ONLY TO COVER BORROWERS WHO HAVE A LOAN UNDER THE INDUSTRIAL LOAN LAW OR THE CALIFORNIA FINANCE LENDERS LAW.

AP 7

APPLICATION FOR CREDIT INSURANCE

You are applying for the insurance marked above. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. You do not have to buy any life insurance to be eligible for disability coverage, or vice versa.

3. You are eligible for disability coverage only if you are working for wages or profit, for 30 hours a week or more, on the Effective Date.

4. Only the Primary Borrower is eligible for life or disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

THIS INSURANCE MAY BE ISSUED ONLY TO COVER BORROWERS WHO HAVE A LOAN UNDER THE INDUSTRIAL LOAN LAW OR THE CALIFORNIA FINANCE LENDERS LAW.

AP 8

APPLICATION FOR CREDIT INSURANCE

You are applying for the insurance marked above. Your signature below means that you agree that you are not eligible for insurance if you have reached your 65th birthday.

Date Primary Borrower Age

THIS INSURANCE MAY BE ISSUED ONLY TO COVER BORROWERS WHO HAVE A LOAN UNDER THE INDUSTRIAL LOAN LAW OR THE CALIFORNIA FINANCE LENDERS LAW.

AP 10

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You ha e the right to stop this authorization Your signature below means that you agree that:

1. You are eligible for insurance as to each advance only if you are working for wages or profit 30 hours a week or more on the date you sign for the advance. If you are not, that particular advance will not be insured until you return to work.

You are insured only for advances actually received by you. You are not insured for any unused credit which may be available to you.

2. Each month the insurance charge is calculated by multiplying the insured outstanding principal balance of your loan on the billing date by the rate shown in the Schedule.

We can change the rate later on. But if we do, we will let you know in advance. The new rate will apply only to charges for insurance made after the date of the rate change.

3. Only the Primary Borrower is eligible for disability insurance.

4. Neither you nor your co–borrower are eligible for insurance after you have reached your 65th birthday, and insurance will also stop when you reach that age.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS. (Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Date of Birth

Co–Borrower Date of Birth

AP 11

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are insured only for advances actually received by you. You are not insured for any unused credit which may be available to you.

2. Each month the insurance charge is calculated by multiplying the insured outstanding principal balance of your loan on the billing date by the rate shown in the Schedule.

We can change the rate later on. But if we do, we will let you know in advance. The new rate will apply only to charges made for insurance after the date of the rate change.

3. Neither you nor your co–borrower are eligible for insurance after you have reached your 65th birthday, and the insurance will also stop on the last day of the month during which you reach that age.

Date Primary Borrower Date of Birth

Co–Borrower Date of Birth

AP 12

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are insured for advances actually received by you. You are not insured for any unused credit which may be available to you.

2. Each month the insurance charge is calculated by multiplying the insured outstanding principal balance of your loan on the billing date by the rate shown in the Schedule.

We can change the rate later on. But if we do, we will let you know in advance. The new rate will apply only to charges made for insurance after the date of the rate change.

3. You are not eligible for insurance after you have reached your 65th birthday, and the insurance will also stop on the last day of the month during which you reach that age.

Date Primary Borrower Date of Birth

AP 13

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that the maximum amount of life insurance is $_____ for ages $_____for ages and $_____for ages_____

Date Primary Borrower Age

Co–Borrower Age

AP 14

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that:

1. The maximum amount of life insurance is $_____for ages_____ $_____ for ages_____and $_____for ages_____.

2. The maximum monthly total disability benefit is $_____for ages,

$_____for ages_____and

$_____for ages.

3. Only the Primary Borrower is eligible for disability insurance.

4. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

AP 15

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that the maximum amount of life insurance is $_____ for ages_____,$_____for ages_____and $_____for ages_____

Date Primary Borrower Age

AP 16

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that:

1. The maximum monthly total disability benefit is $_____ for ages_____, $_____ for ages_____ and $_____ for ages_____.

2. Only the Primary Borrower is eligible for disability insurance.

3. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

AP 17

APPLICATION OF BORROWER

You are applying for the credit insurance marked above. Your signature below means that you agree that:

1. The maximum amount of life insurance is $_____for ages_____, $_____ for ages_____ and $_____ for ages_____.

2. The maximum monthly total disability benefit is $_____for ages_____$_____for ages_____, and $_____ for ages_____.

3. Only the Primary Borrower is eligible for disability insurance.

4. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

Co–Borrower Age

AP 18

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are eligible for insurance as to each advance only if you are working for wages or profit 30 hours a week or more on the date you sign for the advance. If you are not, that particular advance will not be insured until you return to work.

You are insured only for advances actually received by you. You are not insured for any unused credit which may be available to you.

2. Each month the insurance charge is calculated by multiplying the insured outstanding principal balance of your loan on the billing date by the rate shown in the Schedule.

We can change the rate later on. But if we do, we will let you know in advance. The new rate will apply only to charges for insurance made after the date of the rate change.

3. Only the Primary Borrower is eligible for life or disability insurance.

4. You are not eligible for insurance after you have reached your 65th birthday and insurance will also stop when you reach that age.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Date of Birth

AP 19

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are eligible for insurance as to each advance only if you are working for wages or profit 30 hours a week or more on the date you sign for the advance. If you are not, that particular advance will not be insured until you return to work.

You are insured only for advances actually received by you. You are not insured for any unused credit which may be available to you.

2. Each month the insurance charge is calculated by multiplying the insured outstanding principal balance of your loan on the billing date by the rate shown in the Schedule.

We can change the rate later on. But if we do, we will let you know in advance. The new rate will apply only to charges for insurance made after the date of the rate change.

3. Only the Primary Borrower is eligible for disability insurance.

4. You are not eligible for insurance after you have reached your 65th birthday and insurance will also stop when you reach that age.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Date of Birth

AP 20

MEDICAL APPLICATION OF BORROWER

You are applying for the credit insurance marked above. You should understand that untruthful answers to these questions may cancel your insurance protection.

1. Date of Birth_____ Place of Birth_____ Height_____ft._____in. Weight_____lbs. Sex_____M_____F.

2. Occupation_____ Employed By:_____

3. Are you now working 30 hours a week or more at your occupation? ..... Yes___ No___

4. Are you now in good health and free from the effects of any illness or injury? ..... Yes___ No___

5. Have you, during the last five years, had, or been advised to have, advice or treatment for any of the following:

a) Cancer, Tumor, Ulcer, Goiter, Thyroid, Asthma, Tuberculosis, Leukemia ..... Yes___ No___

b) Mental or Nervous Disorder, Paralysis or Convulsions ..... Yes___ No___

c) High Blood Pressure, Rheumatic Fever, Heart Disease, Stroke ..... Yes___ No___

d) Diabetes, Sugar/Albumin in Urine, Prostate Disorder ..... Yes___ No___

e) Impairment of Sight, Speech or Hearing ..... Yes___ No___

f) Disease of Liver, Gall Bladder, Kidneys, or Lungs ..... Yes___ No___

g) Disease or impairment of Bones, Joints, Glands or Muscles ..... Yes___ No___

h) Strained Back, Slipped Disc or Sciatica. ..... Yes___ No___

i) Drug Addiction or Alcoholism ..... Yes___ No___

6. Are you now taking any kind of prescription medication? ..... Yes___ No___

7. Have you been told by a medical professional that you have AIDS or ARC? ..... Yes___ No___

8. Have you ever applied for Life, Accident and Health or Hospital Insurance that was declined or modified? ..... Yes___ No___

Give details of any "No" answers to questions 3 and 4 and any "Yes" answers to questions 5, 6, 7 and 8. Include date, disease, injury or condition, and name and address of doctor or insurance company.

_____

_____

_____

_____

_____

Your signature below means that you agree that:

1. You have read the questions and answers above and they are correct and complete, to the best of your knowledge and belief

2. You are not eligible for insurance if you have reached your 65th birthday.

3. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.

4. Only the Primary Borrower is eligible for disability insurance.

5. AUTHORIZATION TO OBTAIN INFORMATION: You authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of you and any other non-medical information of you, to give to the _____ Insurance Company or its reinsurer any such information. You understand the information obtained by use of the Authorization will be used by the _____ Insurance Company or its reinsurer to determine eligibility for insurance and eligibility for benefits under the policy. Any information obtained will not be released by the _____ Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with your application, claim, or as may be otherwise lawfully required or as you may further authorize.

You may request a copy of this Authorization.

This Authorization shall be valid for two and one half years from the date shown below. A photocopy of this Authorization is as valid as the original.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to your Notice of Proposed Insurance for details.)"

Date Primary Borrower or Co-Borrower

MEDICAL INFORMATION BUREAU PRE-NOTICE
(To be retained by Applicant or Proposed Insured)

Information which you provide will be treated as confidential except that _____ Insurance Company or its reinsurer may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange in behalf of its members. On request by another member insurance company to which you have applied for life or health insurance coverage, or to which a claim is submitted, the M.I.B. will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Disclosure of mental health information may be limited.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act.

The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. _____Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AP 21

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.

3. Each month the life insurance charge is calculated by multiplying the scheduled unpaid balance of your loan on the billing date by the rate shown in the Schedule. The monthly disability insurance charge is calcu-

lated by multiplying the total of the remaining scheduled monthly payments on your loan by the rate in the Schedule.

We can change the premium rates later on. But if we do, we will let you know in advance. The new rates will apply only to charges for insurance made after the date of the rate change.

4. Only the Primary Borrower is eligible for disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

Co–Borrower Age

AP 22

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. Each month the life insurance charge is calculated by multiplying the scheduled unpaid balance of your loan on the billing date by the rate shown in the Schedule.

We can change the premium rates later on. But if we do, we will let you know in advance. The new rates will apply only to charges for insurance made after the date of the rate change.

Date Primary Borrower Age

Co–Borrower Age

AP 23

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.

3. Each month the life insurance charge is calculated by multiplying the scheduled unpaid balance of your loan on the billing date by the rate shown in the Schedule. The monthly disability insurance charge is calculated by multiplying the total of the remaining scheduled monthly payments on your loan by the rate in the Schedule.

We can change the premium rates later on. But if we do, we will let you know in advance. The new rates will apply only to charges for insurance made after the date of the rate change.

4. Only the Primary Borrower is eligible for disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Date of Birth

AP 24

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. Each month the life insurance charge is calculated by multiplying the scheduled unpaid balance of your loan on the billing date by the rate shown in the Schedule.

We can change the premium rates later on. But if we do, we will let you know in advance. The new rates will apply only to charges for insurance made after the date of the rate change.

Date Primary Borrower Age

AP 25

APPLICATION OF BORROWER

You are applying for the credit insurance marked above and authorizing the Creditor to add the charges for insurance to your loan each month as they become due. You have the right to stop this authorization. Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.

3. Each month the disability insurance charge is calculated by multiplying the scheduled monthly payments on your loan by the rate in the Schedule.

We can change the premium rates later on. But if we do, we will let you know in advance. The new rates will apply only to charges for insurance made after the date of the rate change.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS.
(Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Date of Birth

NOTE: Authority cited: Section 779.21 and 779.27, Insurance Code. Reference: Sections 779.6, 779.7, 779.27, 791.06, 799.06 and 10127.5, Insurance Code; Sections 18290–18292, 22314, 22315 and 22455, Financial Code; and Section 120980(f), Health and Safety Code.

HISTORY

1. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
2. Amendment filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
3. Amendment of section and NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.12. Policy and Certificate Blocks.

PA 1

POLICY

(INSTRUCTION: The following paragraph must be printed in at least 14–point type.)

You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.

(INSTRUCTION: The following paragraph must be printed in at least 14–point bold face type.)

If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone

number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

WHAT YOU GET

If we have been paid the premium shown in the Schedule you are insured for the coverage shown in the Schedule as provided in this policy.

PA 2

CERTIFICATE OF INSURANCE

(INSTRUCTION: The following paragraph must be printed in at least 14–point type.)

You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.

(INSTRUCTION: The following paragraph must be printed out in at least 14–point bold face type.)

If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

WHAT YOU GET

We certify that while we are paid the premiums for the Group Policy by the Creditor as they become due each month you are insured for the coverage marked in the Schedule, subject to the terms of the Group Policy issued to the Creditor.

PA 3

CERTIFICATE OF INSURANCE

(INSTRUCTION: The following paragraph must be printed in at least 14–point type.)

You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.

(INSTRUCTION: The following paragraph must be printed in at least 14–point bold face type.)

If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

WHAT YOU GET

We certify that if we have been paid the premium shown in the Schedule you are insured for the coverage shown in the Schedule, subject to the terms of the Group Policy issued to the Creditor.

PA 4

POLICY

(INSTRUCTION: The following paragraph must be printed in at least 14–point type.)

You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.

(INSTRUCTION: The following paragraph must be printed in at least 14–point bold face type.)

If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

WHAT YOU GET

While we are paid the premiums shown in the Schedule as they become due each month you are insured for the coverage marked in the Schedule.

PB 1

WHO GETS PAID

Claim payments are made to the irrevocable Creditor Beneficiary named in the Schedule to pay off or reduce your debt. If claim payments are more than the balance of your debt, the difference will be paid to you or to the Secondary Beneficiary named in the Schedule, if any, or to your estate.

PC 1

WHAT WE WILL PAY

Single Life Insurance Benefit. If you die while you are insured for single life coverage we will pay the amount of insurance in force at the time of your death after we receive proof of your death.

PC 2

WHAT WE WILL PAY

PC 3

Amount of Life Insurance. The amount of life insurance is the outstanding principal balance of your loan on the date of your death plus not more than 2 months unpaid loan interest. But we won't pay more than the Maximum Amount of Life Insurance in the Schedule.

PD 1

Joint Life Insurance Benefit. If you or your co–borrower die while insured for joint life coverage we will pay the amount of insurance in force at the time you or your co–borrower dies after we receive proof of the death. Only one death benefit is payable under this policy.

PE 2

Term of Insurance. The term of insurance coverage starts on the Effective Date (as shown in the Schedule) and stops on the scheduled maturity date of your loan with the Creditor; except that the coverage may stop sooner as described below, under the caption "When Insurance Stops–Refunds."

Amount of Life Insurance. The amount of life insurance is the total amount due on the loan (excluding unearned finance charges), outstanding on the date of the insured borrower's death.

PE 3

Amount of Life Insurance. The amount of life insurance is the total amount due on the loan (excluding unearned finance charges), outstanding on the date of the insured borrower's death. But we won't pay more than the Maximum Amount of Life Insurance in the Schedule.

PE 4

Amount of Life Insurance. The amount of life insurance is the scheduled unpaid balance due on the loan on the date of the insured borrower's death. The amount of life insurance does not include any delinquent payments or unearned interest.

PE 5

Amount of Life Insurance. The Amount of Level Life Insurance shown in the Schedule stays the same while the policy is in effect.

PE 6

Term of Insurance. The term of insurance coverage starts on the Effective Date (as shown in the Schedule) and stops on the scheduled maturity date of your loan with the Creditor; except that the coverage may stop sooner as described below, under the caption "When Insurance Stop—Refunds."

PF 1

Total Disability Insurance Benefit. If you are insured for total disability insurance, we will pay a benefit if you file written proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. The benefit will be equal to 1/30th of your Monthly Total Disability Benefit in the Schedule for each day of disability to be compensated. Payments will stop when you are not totally disabled any more or when benefits are paid to the Scheduled Expiration Date, whichever comes first.

PF 3

Total Disability Insurance Benefit. If you are insured for total disability insurance, we will pay a benefit if you file written proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. Payments will stop when you are not totally disabled anymore or when your loan with the creditor is paid off, whichever comes first. The benefit for each day of disability to be compensated will be 1/30th of your required monthly loan payment or the Maximum Monthly Disability Benefit, whichever is less.

PF 4

Total Disability Insurance Benefit. If you are insured for total disability insurance, we will pay a benefit if you file written proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. The benefit will be equal to 1/30th of your Monthly Total Disability Benefit in the Schedule for each day of disability to be compensated. Payments will stop:

1. when you are not totally disabled any more,
2. when benefits are paid to the Scheduled Expiration Date, or
3. when benefits are paid for the Maximum Disability Benefit Period in the Schedule, whichever comes first.

The amount of Monthly Total Disability Benefit is the same even though your total disability may be due to more than one cause. The Maximum Disability Benefit Period applies to each period of disability.

If benefit payments have stopped and you have recovered and then you become disabled again while still insured for total disability insurance, we may consider it a new period of disability. We will do so only if.

1. since the last period of disability, at least six straight months have passed during which you were not disabled for any period of time or,
2. the new disability is due to an entirely different cause than the previous disability.

PG 1

Definition of Total Disability. During the first 18 consecutive months of your total disability, total disability means that, because of sickness or injury, you cannot perform with reasonable continuity, the substantial and material duties that you must perform to work in your usual occupation in the usual or customary way. Substantial and material duties are duties that are normally required for the performance of your usual occupation and that cannot be reasonably omitted or changed.

After the first 18 consecutive months of your total disability, the definition of total disability changes. It requires that, because of sickness or injury, you cannot work with reasonable continuity in any occupation in which you might reasonably be expected to work satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.

You will be required to give us written proof of your continuing total disability from time to time.

PH 1

WHAT WE WON'T PAY

Misstated Age. If you stated you are under 65, but you are not, we will return your premium when we discover this and will not pay any benefits. This also applies to your co–borrower, if you applied for joint life coverage.

PH 2

WHAT WE WONT PAY

Misstated Age. If you stated you are under 65, but you are not, we will return your premium when we discover this and will not pay any benefits.

PH 3

Misstated Age. If you did not correctly state your age, we will only pay for the amount of insurance that the premium you paid would have bought if your age had been stated correctly. This also applies to your co–borrower, if you applied for joint life coverage.

PH 4

Misstated Age. If you did not correctly state your age, we will only pay for the amount of insurance that the premium you paid would have bought if your age had been stated correctly.

PI 1

Suicide. We won't pay any claim if you commit suicide within 6 months of the Effective Date shown in the Schedule, but we will refund the life insurance premium. This also applies to your co–borrower, if you applied for joint life coverage.

PI 2

Suicide. We won't pay a claim for an advance on your loan if you commit suicide within 6 months after the date of the advance, but we will return the life insurance charge on that advance. This also applies to your co–borrower, if you applied for joint life coverage. The time limit for "Suicide" runs separately as to each advance, but a later advance does not restart the time limit on prior advances.

PI 3

Suicide. We won't pay any claim if you commit suicide within 6 months of the Effective Date shown in the Schedule, but we will refund the life insurance premium.

PI 4

Suicide. We won't pay a claim for an advance on your loan if you commit suicide within 6 months after the date of the advance but we will return the life insurance charge on that advance. The time limit for "Suicide" runs separately as to each advance, but a later advance does not re–start the time limit on prior advances.

PJ 1

Total Disabilities Not Covered. We won't pay the claim or refund the premium if your disability:

1. is a result of normal pregnancy or childbirth or;

2. is a result of an intentionally self–inflicted injury or;

3. begins within 2 years after the Effective Date as a result of a pre–existing medical condition. A pre–existing medical condition is one for which you saw or were under treatment by a physician or a chiropractor both within the 6 months before **and** the 6 months after the Effective Date shown in the Schedule.

PJ 2

Total Disabilities Not Covered. We won't pay a claim or refund the disability insurance charge if your total disability:

1. is a result of normal pregnancy or childbirth or

2. is a result of intentionally self–inflicted injury or

3. as to each advance on your loan, begins within 6 months after the date of the advance as a result of a pre–existing medical condition. A pre–existing medical condition is one for which you saw or were under treatment by a physician or a chiropractor both within the 6 months before **and** the 6 months after the date of the advance.

PK 1

WHEN INSURANCE STOPS–REFUNDS

You can stop this insurance at any time. This insurance stops on the Scheduled Expiration Date, or when your loan is paid off, renewed, refinanced or otherwise stops, whichever happens first. If your insurance stops before the Scheduled Expiration Date in the Schedule, you will be given a refund or a credit on your account of unearned premium. This refund or credit will be calculated using a formula approved by the Insurance Commissioner, but refunds or credits of less than $5.00 won't be made.

PK 2

WHEN INSURANCE STOPS–REFUNDS

You have the right to stop this insurance at any time. This insurance stops automatically on the Final Installment Due Date of your loan with the Creditor, or when your loan is paid off, renewed, refinanced or otherwise stops, whichever happens first. Any coverage under the disability insurance will also stop in the event of your death.

If insurance stops before the Final Installment Due Date of your loan, you will be given a refund or credit on your account of unearned premium. This refund or credit will be calculated using a formula approved by the Insurance Commissioner, but refunds or credits of less than $5.00 won't be made.

PK 3

WHEN INSURANCE STOPS–REFUNDS

You can stop this insurance at any time. This insurance stops on the Scheduled Expiration Date, or when your loan is paid off, renewed, refinanced or otherwise stops, whichever happens first. If your insurance stops before the Scheduled Expiration Date in the Schedule, you will be given a refund or credit on your account of unearned premium. This refund or credit will be calculated on a pro–rata basis, but refunds or credits of less than $5.00 won't be made.

PK 4

WHEN INSURANCE STOPS

This insurance stops:

1. on the first billing date after the Creditor receives your written request to stop the insurance, or

2. on the first billing date after you withdraw your authorization for the addition of charges for the insurance to your loan, or

3. on the first billing date after you reach your 65th birthday, or

4. on the date your loan stops, or

5. on the billing date upon which you are 3 months delinquent in making a minimum monthly payment on your loan, or

6. on the date the Group Policy stops.

PK 5

WHEN INSURANCE STOPS

This insurance stops:

1. on the first billing date after the Creditor receives your written request to stop the insurance, or

2. on the first billing date after you withdraw your authorization for the addition of charges for the insurance to your loan, or

3. on the first billing date after you reach your 65th birthday, or

4. on the date your loan stops, or

5. on the billing date upon which you are 3 months delinquent in making a minimum monthly payment on your loan, or

6. on the date specified in our written notice of cancellation to you.

PK 6

WHEN INSURANCE STOPS

This insurance stops:

1. on the first billing date after the Creditor receives your written request to stop the insurance, or

2. on the Scheduled Expiration Date, or

3. on the date when your loan is paid off, renewed, refinanced or otherwise stops, or

4. on the date when you are 3 months delinquent in payment of a monthly premium for this insurance, or

5. on the date the Group Policy stops.

PK 7

WHEN INSURANCE STOPS

This insurance stops:

1. on the first billing date after the Creditor receives your written request to stop the insurance, or

2. on the Scheduled Expiration Date, or

3. on the date when your loan is paid off, renewed, refinanced or otherwise stops, or

4. on the date when you are 3 months delinquent in the payment of a monthly premium for this insurance, or

5. on the date specified in our written notice of cancellation to you.

PK 8

WHEN INSURANCE STOPS–REFUNDS

You can stop this insurance at any time. This insurance stops on the Scheduled Expiration Date, or when your loan is renewed or refinanced if new insurance is written on the new loan. If your insurance stops before the Scheduled Expiration Date in the Schedule, you will be given a refund or credit on your account of unearned premium. This refund or credit will be calculated using a formula approved by the Insurance Commissioner, but refunds or credits of less than $5.00 won't be made.

PL 1

WHAT THE CONTRACT IS AND HOW YOUR STATEMENTS AFFECT IT

This Policy and the attached Application are the complete contract of insurance. All statements made by you in the Application are considered to have been made to the best of your knowledge and belief. No statement can be used to void this Policy or deny a claim unless that statement is in your signed Application. After 2 years during your lifetime from the Effective Date, no statement made by you in your Application can be used to void this Policy or deny a claim. This does not apply to your disability coverage (if any) if that statement was made fraudulently. If you stated in your Application that you are age 65 or older and we do not return your premium within 75 days of the Effective Date, you are insured.

PL 2

WHAT THE CONTRACT IS AND HOW YOUR STATEMENTS AFFECT IT

The Group Policy, the Application for the Group Policy, and the attached Application of Borrower are the complete contract of insurance. All statements made by you in your Application are considered to have

been made to the best of your knowledge and belief No statement can be used to void this insurance or deny a claim unless that statement is in your signed Application. After 2 years during your lifetime from the Date in the Application, no statement made by you in your Application can be used to void this insurance or deny a. claim. This does not apply to your disability coverage (if any) if that statement was made fraudulently. If you stated in your Application that you are age 65 or older and we do not return your premium within 75 days of the Effective Date, you are insured.

PL 3

WHAT THE CONTRACT IS AND HOW YOUR STATEMENTS AFFECT IT

This Policy and the attached Application are the complete contract of insurance. All statements made by you in the Application are considered to have been made to the best of your knowledge and belief No statement can be used to void this Policy or deny a claim unless that statement is in your signed Application. After 2 years during your lifetime from the Effective Date, no statement made by you in your Application can be used to void this Policy or deny a claim. This does not apply to your disability coverage (if any) if that statement was made fraudulently.

PL 4

WHAT THE CONTRACT IS AND HOW YOUR STATEMENTS AFFECT IT

The Group Policy, the Application for the Group Policy, and the attached Application of Borrower are the complete contract of insurance. All statements made by you in your Application are considered to have been made to the best of your knowledge and belief. No statement can be used to void this insurance or deny a claim unless that statement is in your signed Application. After 2 years during your lifetime from the Date in the Application, no statement made by you in your Application can be used to void this insurance or deny a claim. This does not apply to your disability coverage (if any) if that statement was made fraudulently.

PM 1

RULES FOR FILING A TOTAL DISABILITY CLAIM

You must write us or our agent about your total disability claim within 30 days after the beginning of your total disability or as soon after that as you can. We will send you claims forms within 15 days after you tell us about the claim. If we don't send the forms in 15 days, you can simply send us written proof of your disability. The proof must show the date and the cause of the total disability and how serious it is, and it must be signed by a physician or a chiropractor. The proof of total disability must be sent to us no later than 90 days after the end of each period for which a total disability benefit is payable. If it is impossible to file within 90 days, you must file as soon as you can. Unless you have been legally incapable of filing the proof of total disability, we won't accept if it is filed after one year from the time it should have been filed. You can't start any legal action until 60 days after you send us the proof of your total disability, and you can't start any legal action more than 3 years after the proof is filed.

PN 1

RULES FOR FILING A LIFE CLAIM

We must be given a certified copy of the death certificate as proof of a life claim.

PO 1

CONFORMITY WITH STATE STATUTES

Any part of this policy which, on the Effective Date of this Policy, conflicts with the statutes of the state where the policy was delivered to you is changed to conform to the minimum standards of those statutes.

PP 1

PHYSICAL EXAMINATION AND AUTOPSY

We at our own expense have the right, and you must allow us the opportunity, to examine your person as often as is reasonably required while a claim is pending and to make an autopsy in case of death, if it is not forbidden by law.

PQ 1

_____ _____

Secretary President

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 510, 779.2, 779.3, 779.4, 779.6, 779.14, 779.27, 779.28, 779.30, 779.31, 10113, 10113.5, 10203.5, 10203.55, 10207, 10208, 10209, 10270.94, 10320, 10350–10350.3, 10350.5–10350.7, 10350.10, 10350.11, 10369.1 and 10369. 10, Insurance Code; Sections 18290–18292, 22314, 22315 and 22455, Financial Code; *Erreca v. Western States Life Insurance Co.* (1942) 19 Cal.2d 388; and *Moore v. American United Life Insurance Co.* (1984), 150 Cal. App.3d 610.

HISTORY

1. Amendment of paragraphs PK 1–PK 8 filed 12–29–78; designated effective 4–1–79 and for technical reasons, printed in Register 79, No. 2.
2. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31). 3. Amendment filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
3. Amendment of section and NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).
4. Repealer and new paragraph PG 1 and amendment of NOTE filed 5–27–2008; operative 6–26–2008 (Register 2008, No. 22).

§ 2249.13. Notice of Proposed Insurance Blocks.

A–1

NOTICE OF PROPOSED INSURANCE

The credit life and/or disability insurance you applied for will be effective only if we, _____ Insurance Company, _____ agree to insure you. If we agree to insure you, a policy or certificate which more full; describes the benefits and limitations will be sent to you within 30 days. If we don't insure you, you will be sent a refund or credit on your account of your premium. If you do not receive a policy, a refund or a credit, contact your lender. The insurance will start on the Effective Date in the Schedule.

A–2

NOTICE OF PROPOSED INSURANCE

The credit life insurance you applied for will be effective only if we, _____ Insurance Company, _____ agree to insure you. If we agree to insure you, a policy or certificate which more fully describes the benefits and limitations will be sent to you within 30 days. If we don't insure you, you will be sent a refund or credit on your account of your premium. If you do not receive a policy, a refund or a credit, contact your lender. The insurance will start on the Effective Date in the Schedule.

A–3

NOTICE OF PROPOSED INSURANCE

The credit disability insurance you applied for will be effective only if we, _____ Insurance Company, _____ agree to insure you. If we agree to insure you, a policy or certificate which more full; describes the benefits and limitations will be sent to you within 30 days. If we don't insure you, you will be sent a refund or credit on your account of your premium. If you do not receive a policy, a refund or a credit, contact your lender. The insurance will start on the Effective Date in the Schedule.

B–3

The amount of life insurance is the total amount due on the loan (excluding unearned finance charges), outstanding on the date of the insured borrower's death. If you select joint life, only one death benefit will be payable. We won't pay any claim if you commit suicide within 6 months of the Effective Date.

B–4

The amount of life insurance is the total amount due on the loan (excluding unearned finance charges), outstanding on the date of the insured borrower's death. We won't pay any claim if you commit suicide within 6 months of the Effective Date.

B–5

The amount of decreasing life insurance will be the scheduled unpaid balance of your loan on the date of your death. If you select joint life, only one death benefit will be payable. We won't pay any claim if you commit suicide within 6 months of the Effective Date.

B–6
The amount of decreasing life insurance will be the scheduled unpaid balance of your loan on the date of your death. We won't pay any claim if you commit suicide within 6 months of the Effective Date.

B–7
The amount of level life insurance will stay the same during the Term of Insurance. If you select joint life only one death benefit will be payable. We won't pay any claim if you commit suicide within 6 months of the Effective Date.

B–8
The amount of level life insurance will stay the same during the Term of Insurance. We won't pay any claim if you commit suicide within 6 months of the Effective Date.

B–9
The amount of life insurance is the total amount due on the loan (excluding unearned finance charges), outstanding on the date of the insured borrower's death. But we won't pay more than the Maximum Amount of Life Insurance in the policy or certificate. If you select joint life, only one death benefit will be payable. We won't pay any claim on an advance if you commit suicide within 6 months after that advance.

B–10
The amount of life insurance is the total amount due on the loan (excluding unearned finance charges), outstanding on the date of the insured borrower's death. But we won't pay more than the Maximum Amount of Life Insurance in the policy or certificate. We won't pay any claim on an advance if you commit suicide within 6 months after that advance.

C–1
If you are insured for total disability insurance, we will pay a benefit if you file proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. We won't pay the claim if your disability:
1. is a result of normal pregnancy or childbirth or
2. is a result of an intentionally self–inflicted injury or
3. begins within 2 years after the Effective Date as a result of a pre–existing medical condition. A pre–existing medical condition is one for which you saw or were under treatment by a physician or a chiropractor both within 6 months before **and** 6 months after the Effective Date shown in the Schedule.

C–3
If you are insured for total disability insurance, we will pay a benefit if you file proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. We won't pay the claim if your disability:
1. is a result of normal pregnancy or childbirth or
2. is a result of an intentionally self–inflicted injury or
3. as to each advance on your loan, begins within 6 months after the date of the advance as a result of pre–existing medical condition. A pre–existing medical condition is one for which you saw or were under treatment by a physician or a chiropractor both within 6 months before and 6 months after the date of the advance.

C–4
If you are insured for total disability insurance, we will pay a benefit if you file proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. Payments will stop:
1. when you recover,
2. when benefits are paid to the Scheduled Expiration Date, or
3. when benefits are paid for the Maximum Disability Benefit Period, whichever comes first.

We won't pay the claim if your disability:
1. is a result of normal pregnancy or childbirth or
2. is a result of an intentionally self–inflicted injury or
3. begins within 2 years after the Effective Date as a result of a pre–existing medical condition. A pre–existing medical condition is one for which you saw or were under treatment by a physician or a chiropractor both within 6 months before and 6 months after the Effective Date shown in the Schedule.

D–1
If your insurance stops before the Scheduled Expiration Date in the Schedule, you will be given a refund of unearned premium.
(DRAFTING NOTE: The following paragraph must be printed in at least 14–point type.)
You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.
(DRAFTING NOTE: The following paragraph must be printed in at least 14–point bold face type.)
If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

_____
Primary Borrower

D–2
If your insurance stops before the Final Installment Due Date in the Schedule, you will be given a refund of unearned premium.
(DRAFTING NOTE: The following paragraph must be printed in at least 14–point type.)
You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.
(DRAFTING NOTE: The following paragraph must be printed in at least 14–point bold face type.)
If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

_____
Primary Borrower

D–3
(DRAFTING NOTE: The following paragraph must be printed in at least 14–point type.)
You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you

receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.

(DRAFTING NOTE: The following paragraph must be printed in at least 14–point bold face type.)

If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

Primary Borrower

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 510, 779.3, 779.7, 779.14, 779.27 and 779.30, Insurance Code.

HISTORY

1. Repealer and new section filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
2. Amendment of paragraphs C–1, C–3, C–4 and repealer of paragraph C–2 filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
3. Amendment of section and NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.14. Sample Certificate (Identification Number 11).

Insurer's Name and Complete Address
Called We or Us

SCHEDULE

Primary Borrower, called you, and Address
Co–Borrower, also called you
Source Code
Creditor Beneficiary and Insurance License Number
Class of Business
Secondary Beneficiary
Term of Insurance
Effective Date
Original Amount of Life Insurance
Scheduled Expiration Date
Monthly Loan Payment
Monthly Total Disability Benefit
Decreasing Life: Single ( ) joint ( ) Premium:
Disability: 30–day Elimination Period Premium:
Total Premium:
Maximum Monthly Disability Benefit:
Maximum Amount of Life Insurance:
Group Policy Number
Certificate Number

APPLICATION OF BORROWER

You are applying for the credit insurance marked above, Your signature below means that you agree that:

1. You are not eligible for insurance if you have reached your 65th birthday.

2. You are eligible for disability insurance only if you are working for wages or profit 30 hours a week or more on the Effective Date.

3. Only the Primary Borrower is eligible for disability insurance.

DISABILITY INSURANCE MAY NOT COVER CONDITIONS FOR WHICH YOU HAVE SEEN A DOCTOR OR A CHIROPRACTOR IN THE LAST SIX MONTHS. (Refer to "Total Disabilities Not Covered" in your certificate for details.)

Date Primary Borrower Age

Co–Borrower Age

CERTIFICATE OF INSURANCE

You can cancel this insurance at any time by telling the creditor that you want to do so. You will get back ALL the premium you paid for this insurance if you tell us or the creditor to cancel it within 30 days after you receive this certificate. If you cancel this insurance after 30 days, you will not get back all the premium that you paid.

If you have a question, problem or complaint about this insurance, please contact the Creditor Beneficiary at the address and phone number shown in the Schedule or us at (insert address and telephone number of insurer). If we do not resolve your question, problem or complaint to your satisfaction, you may then contact the

California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927–4357 or (213) 897–8921

WHAT YOU GET

We certify that if we have been paid the premium shown in the Schedule you are insured for the coverage shown in the Schedule, subject to the terms of the Group Policy issued to the Creditor.

WHO GETS PAID

Claim payments are made to the irrevocable Creditor Beneficiary named in the Schedule to pay off or reduce your debt. If claim payments are more than the balance of your debt, the difference will be paid to you or to the Secondary Beneficiary named in the Schedule, if any, or to your estate.

WHAT WE WILL PAY

Single Life Insurance Benefit. If you die while you are insured for single life coverage we will pay the amount of insurance in force at the time of your death after we receive proof of your death.

Joint Life Insurance Benefit. If you or your co–borrower die while insured for joint life coverage we will pay the amount of insurance in force at the time you or your co–borrower dies after we receive proof of the death. Only one death benefit is payable under this policy.

Amount of Life Insurance. The amount of life insurance is the scheduled unpaid balance due on the loan on the date of the insured borrower's death. The amount of life insurance does not include any delinquent payments or unearned interest.

Total Disability Insurance Benefit. If you are insured for total disability insurance, we will pay a benefit if you file written proof that you became totally disabled while insured and continue to be totally disabled for more than 30 days. Payment will be calculated from the 31st day of disability. The benefit will be equal to 1/30th of your Monthly Total Disability Benefit in the Schedule for each day of disability to be compensated. Payments will stop when you are not totally disabled any more or when benefits are paid to the Scheduled Expiration Date, whichever comes first.

Definition of Total Disability. During the first 18 consecutive months of total disability, total disability means that you are not able to perform the major duties of your occupation because of sickness or accidental injury. After the first 18 consecutive months of total disability, the definition changes and requires that you not be able to perform the duties of any occupation for which you are reasonably qualified by education, training or experience. You will be required to give us written proof of your continuing total disability from time to time.

WHAT WE WON'T PAY

Misstated Age. If you stated you are under 65, but you are not, we will return your premium when we discover this and will not pay any benefits. This also applies to your co–borrower, if you applied for joint life coverage.

Suicide. We won't pay any claim if you commit suicide within 6 months of the Effective Date shown in the Schedule, but we will refund the life insurance premium. This also applies to your co–borrower, if you applied for joint life coverage.

Total Disabilities Not Covered. We won't pay the claim or refund the disability premium if your disability:

1. is a result of normal pregnancy or childbirth or

2. is a result of an intentionally self-inflicted injury or

3. begins within 2 years after the Effective Date as a result of a pre-existing medical condition. A pre-existing medical condition is one for which you saw, or were under treatment by a physician or a chiropractor both within the 6 months before and the 6 months after the Effective Date shown in the Schedule.

WHEN INSURANCE STOPS—REFUNDS

You can stop this insurance at any time. This insurance stops on the Scheduled Expiration Date, or when your loan is paid off, renewed, refinanced or otherwise stops, whichever happens first. If your insurance stops before the Scheduled Expiration Date in the Schedule, you will be given a refund or a credit on your account of unearned premium. This refund or credit will be calculated using a formula approved by the Insurance Commissioner, but refunds or credits of less than $5.00 won't be made.

WHAT THE CONTRACT IS AND HOW YOUR STATEMENTS AFFECT IT

The Group Policy, the Application for the Group Policy, and the attached Application of Borrower are the complete contract of insurance. All statements made by you in your Application are considered to have been made to the best of your knowledge and belief. No statement can be used to void this insurance or deny a claim unless that statement is in your signed Application. After 2 years during your lifetime from the Date in the Application, no statement made by you in your Application can be used to void this insurance or deny a claim. This does not apply to your disability coverage (if any) if that statement was made fraudulently. If you stated in your Application that you are age 65 or older and we do not return your premium within 75 days of the Effective Date, you are insured.

RULES FOR FILING A TOTAL DISABILITY CLAIM

You must write us or our agent about your total disability claim within 30 days after the beginning of your total disability or as soon after that as you can. We will send you claims forms within 15 days after you tell us about the claim. If we don't send the forms in 15 days, you can simply send us written proof of your disability. The proof must show the date and the cause of the total disability and how serious it is, and it must be signed by a physician or a chiropractor. The proof of total disability must be sent to us no later than 90 days after the end of each period for which a total disability benefit is payable. If it is impossible to file within 90 days, you must file as soon as you can. Unless you have been legally incapable of filing the proof of total disability, we won't accept it if it is filed after one year from the time if should have been filed. You can't start any legal action until 60 days after you send us the proof of your total disability, and you can't start any legal action more than 3 years after the proof is filed.

RULES FOR FILING A LIFE CLAIM

We must be given a certified copy of the death certificate as proof of a life claim.

PHYSICAL EXAMINATION AND AUTOPSY

We at our own expense have the right, and you must allow us the opportunity, to examine your person as often as is reasonably required while a claim is pending and to make an autopsy in case of death, if it is not forbidden by law.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Sections 510, 779.2, 779.3, 779.4, 779.6, 779.14, 779.27, 779.30, 779.31, 1758.99, 10113, 10113.5, 10203.5, 10203.55, 10207, 10208, 10209, 10127.5, 10320, 10350–10350.3, 10350.5–10350.7, 10350.10, 10350.11, 10369.1 and 10369. 10, Insurance Code; and Section 120980(f), Health and Safety Code.

HISTORY

1. Amendment of paragraph captioned "When Insurance Stops–Refunds" filed 12–29–78; designated effective 4–1–79 and for technical reasons, printed in Register 79, No. 2.
2. Amendment filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
3. Amendment filed 5–23–85; effective thirtieth day thereafter (Register 85, No. 21).
4. Amendment of section heading, section and NOTE filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).

§ 2249.15. Effective Date.

(a) This Article shall be effective as of June 1, 1978. No credit life and/or disability insurance policy, certificate of insurance, notice of proposed insurance, application for insurance, endorsement or rider shall be issued or delivered after April 1, 1979 unless it complies with this Article, including applicable filing requirements. Forms which have been approved pursuant to this Article maybe issued or delivered after, June 1, 1978.

(b) The following forms shall not be issued or delivered after one year following the effective date of the 2006 amendments of this Article:

(1) Standard forms which do not comply with this Article as amended in 2006;

(2) Non–standard forms containing standard text which does not comply with this Article as amended in 2006.

(c) The following forms shall not be issued or delivered after one year following the effective date of the 2008 amendments of this Article:

(1) Standard forms which do not comply with this Article as amended in 2008.

(2) Non–standard forms containing standard text which does not comply with this Article as amended in 2008.

NOTE: Authority cited: Sections 779.21 and 779.27, Insurance Code. Reference: Section 779.27, Insurance Code.

HISTORY

1. Amendment filed 12–29–78; designated effective 4–1–79 and for technical reasons, printed in Register 79, No. 2.
2. Repealer of former Section 2249.15, and renumbering and amendment of former Section 2249.16 to Section 2249.15 filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).
3. Amendment filed 10–2–2006; operative 11–1–2006 (Register 2006, No. 40).
4. New subsections (c)–(c)(2) filed 5–27–2008; operative 6–26–2008 (Register 2008, No. 22).

§ 2249.16. Severability Provision.

If any provision of this Article or the application thereof to any person or circumstance is for any reason held invalid, the remainder of this Article and the application of such provision to any other persons or circumstances shall not be affected thereby.

HISTORY

1. Renumbering and amendment of former Section 2249.16 to 2249.15, and renumbering of former Section 2249.17 to Section 2249.16 filed 7–25–83; effective thirtieth day thereafter (Register 83, No. 31).

Article 7. Workers' Compensation Policy Forms

§ 2250. Dividend Clause.

NOTE: §§2250 and 2251 issued under authority contained in §§11630 to 11742, Insurance Code.

HISTORY

1. Repealer filed 3–3–58; effective thirtieth day thereafter (Register 58, No. 4).

§ 2251. Orthodox Limitations on Dividends Which Need Not Be Stated.

HISTORY

1. Repealer filed 3–3–58; effective thirtieth day thereafter (Register 58, No. 4).

§ 2251.1. Package Policies.

NOTE: Authority cited: Section 11734, Insurance Code. Reference: Sections 11732,11732.1 and 11734, Insurance Code.

HISTORY

1. New section filed 9–20–56; designated effective 10–24–56 (Register 56, No. 18).
2. Amendment filed 11–12–76; designated effective with respect to all new policies with an inception date falling on or after January 1, 1977, and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1977 (Register 76, No. 46).
3. Amendment filed 1–23–78 as an emergency; effective upon filing. Certificate of Compliance included (Register 78, No. 4).
4. Repealer filed 4–11–83; effective thirtieth day thereafter (Register 83, No. 16).

§ 2252. Limiting and Restricting Endorsements.

Limitation or restriction of coverage for liability under the workers' compensation laws of the State of California shall be governed by Sections 2253 to 2268, inclusive.

The workers' compensation coverage provided on a policy that also provides comprehensive personal liability insurance cannot be limited or restricted.

NOTE: Authority cited: Section 11751.5, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code. Additional authority cited: Sections 11650 to 11663, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 11–12–76; designated effective with respect to all new Policies with an inception date falling on or after January 1, 1977, and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1977 (Register 76, No. 46).
3. Amendment filed 1–23–78 as an emergency; effective upon filing. Certificate of Compliance included (Register 78, No. 4).

§ 2253. Endorsements: Attachment and Detachment: Printed or Typed.

Approved forms of endorsement may be attached or detached from any policy at an time. Any approved endorsement may be printed or typewritten provided that wherever the specifications enumerated in Section 2257 require bold–face type, any typewritten forms shall indicate these sections in typewritten caps.

NOTE: Additional authority cited: Sections 11650 to 11663, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).

§ 2254. Same: Changes in Approved Endorsements.

Except as provided in Section 2257, approved endorsement forms must not be changed in any particular but may be combined on one page.

NOTE: Authority cited: Section 11659, Insurance Code.

HISTORY

1. Amendment filed 8–12–54; designated effective 9–15–54 (Register 54, No. 17).

[The next page is 591.]

§ 2255. Same: When Restrictions Printed in Policy: Removal.

Limitations or restrictions of coverage, when stated in the printed body of an approved policy form, may be removed provided the provision removing such limitations or restrictions shall he clearly set forth in an endorsement forming a part of the policy.

NOTE: Additional authority cited: Sections 11650 to 11663, Insurance Code.

HISTORY

1. Amendment filed 104–60, designated effective 1–1–61 (Register 60, No. 21).

§ 2256. Blanks in Approved Forms: Completion and Change.

Any approved policy form may be completed by inserting in the blanks provided therefor the data required by the contract and such inserted provisions may be amended or changed by endorsement or otherwise without in any way affecting the approval of such form of policy.

§ 2257. Limiting and Restricting Endorsements: Specifications for Endorsements.

Each limiting and restricting endorsement shall conform to the following specifications:

(a) It shall have printed in bold face type (or typewritten caps) at the top thereof

"ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING THIS INSURANCE."

(b) The opening statement shall contain the following language:

"The insurance under this policy is limited as follows: It is AGREED that, anything in this policy to the contrary notwithstanding, this policy (or "such insurance as is afforded by the policy by reason of the designation of California in Item 3 of the declarations") DOES NOT INSURE" (or "DOES NOT EXTEND TO OR COVER" or DOES NOT APPLY"),

(c) It shall have a marginal notation printed in bold face type (or typewritten caps) indicating the character of the limitation or restriction stated in the endorsement.

(d) It shall have printed in bold face type (or typewritten caps) the following footnote:

"FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES, AND OTHER SUBSTANTIAL PENALTIES (Labor Code Section 3710. 1, et seq.)"

(e) If the policy does not by its terms provide that remuneration when used as a premium basis shall not include the remuneration of an employee with respect to whom coverage is not afforded, Endorsement Forms Nos. 4, 10 and 11 shall include the following provision:

"It is further agreed that 'remuneration' when used as a premium basis for such insurance as is afforded by this policy (or "by the policy by reason of the designation of California in Item 3 of the declarations") shall not include the remuneration of any person excluded from coverage in accordance with the foregoing."

(f) When appropriate, the words, "the insured" maybe substituted in any of the approved endorsements for "this employer," "the insured employer," "the employer," "the named employer."

(g) The wording and the form for that portion of each California Approved Form endorsement commencing with "Applicable to and forming a part of" and continuing to and including the signature lines are optional and may be rearranged to suit the needs of each insurer; provided that if the endorsement is not attached to the policy at original issuance it shall include provisions adequate to clearly identify the insurer, insured and policy involved, the date of the endorsement and be executed with sufficient authentication to establish its genuineness.

NOTE: Authority cited: Sections 11732, 11732. 1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. Amendment filed 8–12–54; designated effective 9–15–54 (Register 54, No. 17).
2. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
3. Amendment to subsection (e) filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
4. Amendment of subsections (d) and (e) filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2258. Form Numbers Required.

Each limiting and restricting endorsement form must bear the appropriate California Approved Form number. In addition, all workmen's compensation policy and endorsement forms must bear the insurer's identifying form number and imprint date.

NOTE: Authority cited: Section 11659, insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).

§ 2259. Grounds for the Use of Limiting and Restricting Endorsements.

A limiting and restricting endorsement other than California Approved Form Endorsement No. 11 may be used only under one or more of the following circumstances:

(a) Where the purpose of the endorsement is to limit insurance coverage to the liability for compensation to employees of the specific entity named as the insured in the policy.

(b) Where the insured seeks to exclude an individual whose relationship by blood or marriage to the insured suggests family rather than employment ties, particularly if the insured denies the existence of employment.

(c) Where the insured seeks by endorsement to negate an "election" under Labor Code Section 4151 to bring under the compensation provisions of the Labor Code persons in his employment who are excluded from the definition of "employee" by Section 3352 and other provisions of Article 2 of Chapter 2 of Part 1 of Division 4 of the Labor Code.

(d) Where the endorsement serves as a notice to the employer that any liability for additional compensation payable to his employee by reason of injury caused by the employer's serious and willful misconduct, or liability by reason of the illegal employment of a minor under 16 years of age, is uninsurable (Insurance Code Sections 11661 and 11661.5).

(e) Where the endorsement seeks to exclude only such liability of the employer for compensation as the latter affirms to the insurer in writing is otherwise secured or is lawfully uninsured (e.g., liability of the State and its political subdivisions and institutions).

(f) Where the endorsement seeks to exclude an employee who is covered for workers compensation benefits on a policy also affording comprehensive personal liability insurance.

NOTE: Authority cited: Sections 11732, 11732.1, 11734 and 11751.5, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
2. New subsection (g) filed 11–12–76; designated effective with respect to all new policies with an inception date falling on or after January 1, 1977, and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1977 (Register 76, No. 46).
3. Amendment of subsection (g) filed 1–23–78 as an emergency; effective upon filing. Certificate of Compliance included (Register 78, No. 4).
4. Repealer of former subsection (b) and sequential redesignation of subsequent sub–sections filed 12–1–78 as an emergency; designated effective 1–1–79. Certificate of Compliance included (Register 78, No. 48).

§ 2260. California Approved Form Endorsements.

Endorsement Forms Nos. 1C, 4, 7, 10, 11, 13 and 14, copies of which appear in Sections 2269.1 to 2269.14, inclusive, are California Approved Form Endorsements.

NOTE: Authority cited: Sections 11732,11732.1. and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment and renumbering of Section 2259 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2261. Same: Submission Requirements.

Each insurer must submit its California Approved Form limiting and restricting endorsement forms to the Workers' Compensation Insurance Rating.Bureau of California in duplicate for examination by the Bureau.

NOTE: Authority cited: Sections 11732,11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (For history of former Section 2260, see Register 54, No. 17.)
2. Amendment and renumbering of Section 2260 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).
4. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2262. Other Limiting and Restricting Endorsements: Approval.

All other limiting or restricting endorsement forms must be drafted in accordance with and subject to the specifications enumerated in Section 2257, and must be submitted in duplicate to the Workers' Compensation Insurance Rating Bureau of California for its examination and transmittal to the Insurance Commissioner. After consultation with the Workers' Compensation Appeals Board as required by law, the insurer will be notified of approval or disapproval of any such form.

NOTE: Authority cited: Sections 11732, 11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (Ed. Note: Similar to former Section 2263.)
2. Amendment and renumbering of Section 2261 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).
4. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2263. Limiting and Restricting Provisions in Policy Forms.

Each limiting or restricting provision which is incorporated as an integral part of policy form is subject to the standards stated in Section 2259 (a) through (f) of these rules.

NOTE: Authority cited: Sections 11732, 11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
2. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2264. Options for Form No. 10.

California Approved Form Endorsement No. 10 may be completed by the insertion of one of the following options and none other:

(a) (Insert only the names of persons to be specifically excluded.)

(b) "Any employee engaged in any work other than directly in connection with the operation specifically described in the policy schedule ("information page" or "declarations") or amendment of such schedule ("information page" or "declarations") by endorsement."

(c) "Any employees engaged in any work not directly connected with operations conducted at (or "in") . . . " (Insert here a careful description of the location to be excluded.)

(d) "Any employee engaged in any work directly connected with operations conducted at (or "in.") . . . " (Insert here a careful description of the location to be excluded.)

(e) "Any employee engaged in the following operations . . ." (Insert here a careful description of the operations to be excluded and the manual classification and code number applicable to such operations.)

(f) "Any employee engaged in the following operations: . . ." (Insert here a careful description of the operations and manual classification and code number applicable thereto) "at or from.." (Insert here a careful description of location to be excluded.)

(g) "Any employees other than those engaged in the following operations " (Insert here a careful description of operations and manual classification and code number applicable thereto) "at or from . . ." (Insert here a careful description of the location to be covered.)

(h) "Any employee who is covered for workers' compensation benefits on a policy also affording comprehensive personal liability insurance which has been issued to this insured."

NOTE: Authority cited: Sections 11659 and 11751.5, Insurance Code. Reference: Sections 11657, 11658 and 11659, and Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (Ed. note: Similar to former Section 2260; for history, see Register 54, No. 17.)
2. Amendment and renumbering of Section 2263 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. New subsection (h) filed 11–12–76; designated effective with respect to all new policies with an inception date failing on or after January 1, 1977, and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1977 (Register 76, No. 46).
4. Amendment of subsection (h) filed 1–23–78 as an emergency; effective upon filing. Certificate of Compliance included (Register 78, No. 4).
5. Amendment filed 12–30–83; designated effective 1–1–84 pursuant to Government Code Section 11346.2(d) (Register 84, No. 1).

§ 2265. Use of Form No. 11 Restricted.

California Approved Form Endorsement No. 11 may be used only in those cases where other California Approved Form Endorsements are not applicable or may not be used. It shall accurately and unambiguously state the limitations or restriction and shall bear an appropriate side note descriptive of the limitations or restriction. It may be used only under one or more of the following circumstances:

(a) Where use of the Form No. 11 Endorsement is in accordance with one or more of the guiding standards set forth in Section 2259 of these rules.

(b) Where the employer's business is conducted in such a manner that it is impossible or impracticable to determine the nature, scope and extent of employment covered by the insurer without the use of a limiting and restricting endorsement.

(c) Where the use of the Form No. 11 Endorsement is for the intended purpose of preventing performance of work in such an extremely hazardous manner or under such hazardous conditions as would reflect a reckless disregard by the employer for the welfare of his employees.

(d) Where the issuance of an unrestricted policy would serve to encourage an operation which is illegal, clearly contrary to public interest, or contrary to the rules or practices of a public regulatory.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (Ed. note: Similar to former Section 2261.)
2. Amendment and renumbering of Section 2264 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

§ 2266. Use of Form No. 11; Notification to Insured.

Upon issuance of any completed California Approved Form Endorsement No.11 the insurer must submit such endorsement in triplicate to the Workers' Compensation Insurance Rating Bureau of California. Upon receipt of such Form No. 11 endorsement, the Bureau shall notify the insured in writing, with duplicate copy to be furnished the Division or Industrial Accidents, of the nature of the limitation or restriction. Such notification shall also inform the insured that in the event of a claim arising within the scope of the limitations, which the Division of Industrial Accident should hold to be compensable, the employer would be directly li-

able under the law and not protected by the policy. Such endorsement shall then be transmitted to the Insurance Commissioner. Each such endorsement shall be deemed to be approved by the Insurance Commissioner unless, within 30 days from the date of submission by the Workers' Compensation Insurance Rating Bureau of California the Insurance Commissioner shall in writing notify the insurer submitting the endorsement that same is disapproved. If such notification of disapproval is not given within said 30 days, all such endorsements shall be deemed to be approved until 10 days after the date of written notification of disapproval.

NOTE: Authority cited: Sections 11659 and 11650–11663, Insurance Code. Reference: Section 11690—11742, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (Ed. note: Similar to former Section 2262.)
2. Amendment and renumbering of Section 2265 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2267. Extension of Coverage to New Insured: Not Limiting Endorsement.

The extension of the policy by endorsement to cover the liability of anyone in addition to the original named insured, shall, unless otherwise stipulated in the endorsement, extend the same coverage as that provided by the policy to the original named insured. It shall not be necessary to set out in such endorsement the restrictions or limitations, if any, of the policy, nor shall such endorsements be considered limiting or restricting endorsements.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (Ed. note: Same as former Section 2264.)
2. Renumbering of Section 2266 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

§ 2268. Collateral Agreements Prohibited Unless Made Part of Policy.

No collateral agreements modifying the obligation of either the insured or the insurer shall be made unless attached to and made a part of the policy, provided, however, that if such agreements are attached and in any way restrict or limit the coverage of the policy, they shall conform in all respects with these rules.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21). (Ed. note: Same as former Section 2265.)
2. Renumbering of Section 2267 filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

§ 2269.1. California Approved Form Endorsement No. 1C.

CALIFORNIA
APPROVED FORM NO. 1C

Endorsement Agreement
Limiting and Restricting This Insurance

WORKMEN'S COMPENSATION AND EMPLOYERS' LIABILITY POLICY AMENDATORY ENDORSEMENT—CALIFORNIA

It is AGREED that such insurance as is afforded by the policy by reason of the designation of California in Item 3 of the declarations is subject to the following provisions:

1. Serious and Willful Misconduct and Additional Compensation for Minor's Illegal Employment not Insured

The policy does not apply to liability for additional compensation imposed on the insured under Sections 4553 and 4557, Division IV, Labor Code of the State of California, by reason of the serious and willful misconduct of the insured or any representative of the insured or by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.

2. Application of Policy

With respect to Coverage A, Insuring Agreement IV, "Application of Policy" is amended to read as follows:

This policy applies only to injury (1) by accident occurring during the policy period, or (2) by disease caused or aggravated by exposure during the policy period to conditions in the course of employment by the insured.

3. Exclusion under Coverage B—Employers' Liability

Exclusion (b) of the policy is amended to read as follows:

This policy does not apply under coverage B with respect to any employee employed in domestic employment not described in the declarations unless the policy applies under coverage A with respect to such employee.

It is further agreed that the policy, including all endorsements forming a part thereof, constitutes the entire contract of insurance. No condition, provision, agreement, or understanding not set forth in the policy or such endorsement shall affect such contract or any rights, duties, or privileges arising therefrom.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____ this _____ day of _____ 199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: Authority cited: Sections 11732, 11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2269.2. California Approved Form Endorsement No. 2.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Repealer filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date failing on or after April 1, 1968 (Register 67, No. 38).

§ 2269.3. California Approved Form Endorsement No. 3.

NOTE: Authority cited: Sections 11732, 11732.1 and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective data falling on or after April 1, 1968 (Register 67, No. 38).
3. Repealer filed 12–1–78 as an emergency; designated effective 1–1–79. Certificate of Compliance included (Register 78, No. 48).

§ 2269.4. California Approved Form Endorsements No. 4.

CALIFORNIA
APPROVED FORM NO. 4

Endorsement Agreement
Limiting and Restricting This Insurance

If this policy is issued to an individual or to a husband and wife either as individuals or as a partnership, the insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

Relatives Not Insured

As respects injury (or death resulting therefrom) sustained by any of the following relatives of the employer and spouse, or of either, i.e.,

spouse, child by birth or adoption, stepchild, grandchild, son–in–law, daughter–in–law, parent, stepparent, parent–in–law, grandparent, brother, sister, stepbrother, step–sister, half–brother, half–sister, brother–in–law, sister–in–law, uncle, aunt, nephew or niece. IF at the time of injury such relative (1) resides in the household of the employer and spouse or of either, or (2) is a child under the age of 12 years, unless such relative is included specifically by name in the schedule of operations of the declarations or is specifically insured by name in an endorsement attached to this policy.

Nothing in this endorsement contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations of this endorsement.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____this_____day of _____199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: Authority cited: Sections 11732, 11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. Amendment filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2269.7. California Approved Form Endorsement No. 7.

CALIFORNIA
APPROVED FORM NO. 7

Endorsement Agreement
Limiting and Restricting This Insurance

The insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

Medical Benefits Not Insured

To any employee any medical, surgical and hospital treatment, nursing, medicines, medical and surgical supplies, crutches and apparatus, artificial limbs and transportation charges required by Section 4600 of the Labor Code. It is agreed that said benefits shall be provided by the employer at his own expense.

It is further understood and agreed that said treatment shall be provided by the employer in accordance with the provisions of the said Labor Code, and /or rulings and orders of the Workmen's Compensation Appeals Board of the State of California, and also to the satisfaction of the said_____ COMPANY.

It is further understood and agreed that notwithstanding this exclusion, the employer named in this policy expressly agrees, authorizes and grants to the _____Company, at the expense of the employer, the right to control, direct, change, supplement or modify, the medical, surgical or hospital treatment to be furnished by the employer to injured employees.

Nothing in this endorsement contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations of this endorsement.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____this_____day of _____199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: Authority cited: Sections 11659, 11732, 11732.1 and 11734, Insurance Code. Reference: Sections 11657,11658 and 11659 and, Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).
4. Amendment filed 12–30–83; designated effective 1–1–84 pursuant to Government Code Section 11346.2(d) (Register 84, No. 1).

§ 2269.9. California Approved Form Endorsement No. 9.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Repealer filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

§ 2269.10. California Approved Form Endorsement No. 10.

CALIFORNIA
APPROVED FORM NO. 10

Endorsement Agreement Limiting and Restricting This Insurance

The insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE

Employees and/or	As respects injury(or death resulting
Operations and/or	therefrom) sustained by
Locations	(Insert here option filler; See Section 2264)
Not insured	

Nothing in this endorsement contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations of this endorsement.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____this_____day of _____199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: Authority cited: Sections 11732,11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2269.11. California Approved Form Endorsement No. 11.

CALIFORNIA
APPROVED FORM NO. 11

Endorsement Agreement
Limiting and Restricting This Insurance

The insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

Nothing in this endorsement contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations of this endorsement.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____this_____day of _____199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: Authority cited: Sections 11732,11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21)
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2269.12. California Approved Form Endorsement No. 12.

HISTORY

1. New section filed 104–60; designated effective 1–1–61 (Register 60, No. 21).
2. Repealer filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

§ 2269.13. California Approved Form Endorsement No. 13.

CALIFORNIA
APPROVED FORM NO. 13

Endorsement Agreement
Limiting and Restricting This Insurance

If this policy is issued to a partnership, the insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE

Liability Not Insured — Any liability the named employer may have or acquire other than as a partnership, "jointly and not severally."

Nothing in this endorsement contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations of this endorsement.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____this_____day of _____199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: Authority cited: Sections 11732,11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2269.14. California Approved Form Endorsement No. 14.

CALIFORNIA
APPROVED FORM NO. 14

Endorsement Agreement
Limiting and Restricting This Insurance

The insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE

Liability Not Insured — Any liability which the named employer may have arising out of operations conducted jointly by said named employer with any other person, firm or corporation, except as specifically set forth in Item (1) of the declarations or by endorsement attached to this policy.

Nothing in this endorsement contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements, or limitations of this endorsement.

Applicable to and forming part of Policy No. _____
Issued by the _____
To _____ of _____
Dated at _____this_____day of _____199__
Countersigned _____

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES
(Labor Code Section 3710.1, et seq.).

NOTE: : Authority cited: Sections 11732,11732.1, and 11734, Insurance Code. Reference: Articles 2 and 3 of Chapter 3, Part 3, Division 2, Insurance Code.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Amendment filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).
3. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).

§ 2269.15. California Approved Form Endorsement No. 15.

HISTORY

1. New section filed 10–4–60; designated effective 1–1–61 (Register 60, No. 21).
2. Repealer filed 9–18–67; designated effective with respect to all policies and endorsements with an effective date falling on or after April 1, 1968 (Register 67, No. 38).

Article 8. Surety Bonds

§ 2270. Consideration or Premium to Be Stated.

In conformity with Attorney General's Opinion No. NS–3736, it is hereby ordered that all surety bonds issued by insurers in the State of California on or after October 1 1941, comply with the following conditions:

(a) Such bonds shall state the entire consideration or premium paid therefor.

(b) Such statement of consideration, if not contained in the text of the bond, shall be attached thereto by endorsement or stamped thereon prior to delivery of said bond.

Article 9. Extension of Covering Notes

§ 2271. Extension of Covering Notes.

This article governs the extension of covering notes beyond 90 days from the effective date of the original covering note without the written approval of the Commissioner and is for the purpose of preventing the violation of any provision of the Insurance Code by such extension without such written approval.

HISTORY

1. New 2271 to 2274.5 inclusive, filed 4–30–48 (Register 12, No. 5).

§ 2272. Effective Date of Article.

This article shall take effect at 12.01 a.m., Pacific Standard Time, on June 1, 1948.

§ 2273. Definitions.

As used in this article:

(a) The term "covering note(s)," etc. includes binder, binder letters, or any similar agreement which provides temporary insurance, other than a policy or certificate of insurance.

(b) The terms "extension(s)" and "renewal(s)" are synonymous and includes any means by which coverage granted by a covering note is kept in force other than by the issuance of a policy or certificate of insurance.

(c) The terms "extend" and "renew" mean the act whereby the extension or renewal of a covering note is accomplished.

RULES

§ 2274. Authority to Extend Beyond 90 Days.

Any insurer may extent or renew any covering note issued by it beyond 90 days from the effective date of the original cover note without the written approval of the commissioner, in accordance and subject to all conditions set forth in Sections 2274.1 to 2274.5, and said sections pertain only to such extension or renewal.

§ 2274.1. Terms of Coverage Limited to 150 Days.

The extension or renewal may be for a period or periods which, when added to the original 90–day period, will not grant coverage under covering notes for a period in excess of 150 days from the effective date of the original covering note.

§ 2274.2. Contents of Covering Note and Insurer's Record Prescribed.

The covering note and its extension or renewal must be in writing, and the insurer must maintain a permanent record of the original covering note and of all renewals or extensions thereof. Such record and the covering note must contain the following:

(a) Name of the insured.

(b) The property or liability insured.

(c) The amount of insurance.

(d) The risks insured against.

(e) The commencement and termination dates of the covering note.

(f) The basis or rates upon which the final premium is to be determined and paid. (If the risk falls within a definite schedule of rates used by the insurer, this rule may be complied with by a declaration in the note and the records that the premium will be based upon such a schedule.)

(g) If the extension or renewal is by a separate covering note, or if the entry in the records is a separate entry, such note and/or such entry must refer to and identify the original note or entry.

§ 2274.3. Policy Must Be Issued; Minimum Period and Risks to Be Covered by Policy Prescribed.

At or before the expiration of the extension or renewal, or at the expiration of such further extensions or renewals as may be specifically granted in writing by the Insurance Commissioner, a policy of insurance must be issued covering the insured, the risks bound by the covering note, and commencing with the effective date of the original covering note at least the period of time included in all covering notes.

§ 2274.4. Earned Premium Must Be Charged: Rate May Not Be Unfairly Discriminatory; When Separate Charge Need Not Be Made.

An earned premium must be charged for the insurance bound by covering notes. Such earned premium shall not be unfairly discriminatory, but shall be consistent with the premium rates usually used by the insurer for risks of the nature of that bound by the covering note. When the policy issued pursuant to Section 2274.3 covers not only the period of time included in all of the covering notes but extends beyond the termination of the last one thereof, then the earned premium may be included in the premium charged under the policy and need not be charged separately therefrom.

§ 2274.5. Risks Eligible for Automatic Extension Defined.

The risk to be bound under the covering note to be extended or renewed must be one for which, by reason of the unavailability of an average rate, the in ability to determine the value of the property, or the physical inability to make a survey or inspection of the hazards, it is impossible to issue an insurance policy in the ordinary course of business within 90 days. A covering note binding a risk which does not fall within on of the following categories shall not be eligible for automatic extension. A risk which does fall within one of the following categories shall be prima facie deemed to have met the requirements of this section.

(a) The property insured is in five or more separate locations.

(b) The premium which it is estimated the risk will develop will be:

(1) $400 or more per annum in the case of fire insurance.

(2) $250 or more per annum in the case of insurance other than fire.

(3) If the parties contemplate the issuance of a policy with a term other than one year, then the estimated premium must be at least in an amount which is either in the same ratio to the $400 or $250, respectively, as the term of the policy is to one year, or, if the insurer calculates its premiums for such a policy on a multiple or fraction of the one–year premium, equal to such multiple or fraction of the $400 or $250, respectively.

(c) The risk is one which normally requires a survey or inspection and is located in excess of 100 miles by usual routes of travel from any city having, by the latest regular United States census, a population of 100,000 or more.

Subchapter 3. Insurers

Article 1. Admission Requirements

§ 2275. General Consideration: Operating Record and Financial Condition: Minimum Capital Does Not Guarantee Admission.

The commissioner will, in considering an applicant insurer for admission to transact business in California, determine each case largely upon its individual merits as to operating record and financial condition, and a reasonable surplus sufficient to meet all ordinary contingencies will be required in every case in addition to the minimum capital requirements specified in the statutes. The applicant must establish that its financial

condition is such that the policyholders and creditors with which it will deal will be reasonably safe. Compliance with the minimum capital requirements does not guarantee admission. Each application for admission is determined after a consideration of all of the qualifications of the applicant.

§ 2276. When Examination Required.

The examination permitted by Section 731 of the Insurance Code of the business and affairs of foreign insurers applying for admission in the State of California will be required in the case of all foreign insurers seeking admission, who do not meet all of the following requirements:

(a) Such insurer has transacted insurance business under the same corporate name and management for at least five years immediately preceding the date of its application for admission to the State of California.

(b) Such insurer is, and for at least five years immediately preceding the date of its application for admission to the State of California, has been, authorized to transact an insurance business in not less than five states.

(c) Such insurer, through its duly authorized officers who have full knowledge of the facts, files a verified statement under oath that it has never been denied admittance in any state and that its certificate of authority to transact business in any state has never been revoked or suspended.

(d) Such insurer has been officially examined by the insurance commissioner or similar official of its home state as of a date not more than two years preceding the date of its application for admission to California.

(e) Such insurer, in addition to all other papers required to be filed, files with this department a certified copy of the last report of such examination.

(f) Such insurer has a cash capital of not less than $500,000 and a surplus over all liabilities of not less than $250,000.

The foregoing regulation is not to be construed as waiving the statutory right of the Insurance Commissioner to make or cause to be made such examination in the case of any such foreign insurer who meets all of the foregoing requirements.

§ 2277. Compliance with Requirements of Secretary of State.

The applicant insurer shall notify the commissioner of its transmission to the Secretary of State at Sacramento of its articles of incorporation and all amendments thereto, designation of representative for process and the payment of fees required therefor. The commissioner will not issue a certificate of authority until these requirements have been met.

Article 1.1. Holocaust Era Insurance Registry

NOTE: The Department of Insurance had been enjoined from enforcing the regulations in this article. The Office of Administrative Law approved the readoption of these emergency regulations, initially adopted on 1–13–2000 and refiled on 2–8–2000, 5–30–2000, 9–20–2000, 1–16–2001, 5–11–2001, 9–4–2001, 1–2–2002, 5–1–2002, 8–28–2002, 12–26–2002, 4–24–2002 and 8–25–2003, pursuant to subdivision (h) of Government Code section 11346.1 in order to maintain the status quo pending the outcome of the litigation. The litigation has been resolved in favor of the parties seeking the injunction and the regulations have been repealed 9–9–2003 pursuant to section 100, title 1, California Code of Regulations. For prior history of article 1.1, sections 2278–2278.5, see Register 2003, No. 35.

Article 2. Valuation of Properties and Securities

§ 2279. Rules and Regulations for Valuation of Securities—General.

The rules and regulations for the valuation of securities set forth in this article are adopted and promulgated as a necessary part of, and as instructions for the proper and uniform preparation and filing of financial statements and reports required by the California Insurance Code and the Insurance Commissioner, on a uniform basis according to kinds of insurance business transacted, to insurers to elicit from them a true exhibit of their financial condition, and to make certain and uniform, and to give advance notice as to the manner in which the Insurance Commissioner will initially exercise the discretion given to him by Sections 1250 to 1253, inclusive, 1430, 11131 and 12921 of the California Insurance Code relative to valuation of securities reported by insurers in financial statements filed with him and relative to the forms of financial statement and the valuation of securities reported therein required to be filed with him by insurers, including Reciprocal Insurers and Fraternal Insurers. The duties and discretion of the Insurance Commissioner conferred on him by laws as to the proper valuation of securities and properties held by insurers cannot be, and are not exhausted by these rules and regulations.

NOTE: Authority cited: Sections 923, 1250 to 1253, inclusive, 1430, 11131 and 12921, Insurance Code.

HISTORY

1. Amendment filed 2–4–71 as an emergency; effective upon filing (Register 71, No. 6). For prior history, see Register 69, No. 13.
2. Certificate of Compliance–See. 11422.1, Government Code, filed 3–12–71 (Register 71, No. 11).

§ 2280. Definitions.

(a) The term "association value" of a particular security as used in this article means the value of such security as established, promulgated, and recommended for use by the Committee on Valuation of Securities of the National Association of Insurance Commissioners, 60 Wall Street, New York, N.Y. 10005.

(b) Except where the context provides to the contrary, the words "financial statements" as herein below used in this article mean the financial statements and reports required of any insurer admitted to do business in the State of California, for the purpose of exhibiting the company's condition and affairs which the statements and reports are or may be required to be filed with the Insurance Commissioner of the State of California.

(c) The term "subsidiary company " shall mean a corporation more than 50% of the outstanding capital stock of which is owned or controlled, directly or indirectly, by the reporting insurer or by a corporation affiliated with the reporting corporation, or by any or all of these.

HISTORY

1. Amendment filed 2–4–71 as an emergency; effective upon filing (Register 71, No. 6). For prior history, see Register 70, No. 27.
2. Certificate of Compliance–Sec. 11422.1, Government Code, filed 3–12–71 (Register 71, No. 11).

§ 2281. Valuations.

(a) The Insurance Commissioner will require that in the annual statement to be filed as required by the provisions of the Insurance Code, all securities and properties be valued as herein–after prescribed or permitted.

§ 2282. Bonds and Stocks.

(a) It is the intention of the Insurance Commissioner to accept on a prima facie basis for purposes of valuation of bonds and stocks, the "association value" subject to any limitations imposed by the Insurance Code of the State of California, provided that:

(1) A stock, bond or other evidence of debt if in default as to principal or interest or if not amply secured, shall not be valued as an asset of the insurer above its market value.

(2) The amortized values of amortizable bonds received under reorganization or capital readjustments may, with the approval of the Commissioner, continue at the time of such reorganization or capital readjustments to be based on the previously existing amortized cost, rather than current market value.

(b) It is the intention of the Insurance Commissioner to require that a mandatory securities valuation reserve be established in accordance with the rules and instructions of the Committee on Valuation of the National Association of Insurance Commissioners.

HISTORY

1. Amendment filed 2-7-69 as an emergency; designated effective 2-7-69 (Register 69. No. 6).
2. Amendment filed 3-25-69 as an emergency; effective upon filing Certificate of Compliance included (Register 69, No. 13).
3. Amendment filed 2-4-71 as an emergency; effective upon filing (Register 71, No. 6).
4. Certificate of Compliance-Sec. 11422. 1, Government Code, filed 3-12-71 (Register 71, No. 11).

§ 2283. Mortgages: General Rules Relating to Mortgages Purchased at a Premium or at a Discount and Which Are Not More Than Three Months in Default.

Notes secured by mortgage or deed of trust on real property which are not more than three months in arrears of either principal or interest, and on the property securing which no taxes, assessments or other charges constituting liens are in arrears or have been advanced by the reporting insurer or an affiliate thereof, shall be valued at amounts equal to the unpaid principal of such notes (but not in excess of the amount permitted by law to be loaned on or invested in such notes) with the following exceptions:

(a) FHA and VA Mortgages. Premiums may be amortized and discounts accrued on FHA and VA mortgages over a five-year period from date of acquisition. Companies may adjust the asset values of these mortgages to the face amounts thereof, but any excess of aggregate value over aggregate permissive amortized value (cost of mortgages less repayments of principal, adjusted for amortization of premiums and accrual of discounts on a five-year basis) shall be treated as a "not admitted asset."

(b) Mortgages (Insured or Guaranteed by the Federal Housing Administration or the Veterans Administration) Received in Exchange for 2 3/4% Treasury Bonds, Investment Series "B"—1975-1980, Nontransferable. Acquisition cost to insurers shall be equal to the amortized value of the bonds surrendered in the exchange at the date of exchange, provided, however, that in no event shall such acquisition cost exceed the principal amount owing upon the mortgage at the time of acquisition by the insurer.

(c) Mortgages (Other Than FHA and VA Mortgages). The book value of real estate mortgages acquired at a premium may be reported at values reflecting write-offs of such premiums over a three-year period from date of acquisition. Real estate mortgages purchased at a discount should be carried at cost.

§ 2284. Notes in Arrears More Than Three Months.

All notes secured by mortgage or deed of trust on real property, which are in arrears more than three months of either principal or interest, or on the property securing which any taxes, assessments or other charges constituting liens are in arrears or have been advanced by the reporting insurer or an affiliate thereof, shall be valued at amounts not in excess of the lowest of the following:

(a) 90% of the reasonable value on December 31 of the property securing such several notes, except in the case of government guaranteed or insured obligations.

(b) The unpaid principal of such several notes without addition of interest in arrears or accrued and without addition of advances made.

(c) The amount permitted by law to be loaned on, or invested in, such several notes.

Advances made on such notes must not be listed elsewhere as assets unless also deducted as "Assets Not Admitted." Interest on such notes which are in arrears shall not, unless also deducted under "Assets Not Admitted," be listed elsewhere as an asset in excess of the amount permitted by the valuation requirements of the Department of Insurance of the reporting insurer's state of domicile, nor in excess of interest in arrears one year.

§ 2285. Collateral Loans: Basis of Valuation.

Notes secured by collateral other than real property shall be valued at amounts determined for each such note and each security pledged therefor, not exceeding 85% of the value of such security pledged, determined in accordance with the rules herein, applicable to securities or property owned, nor exceeding in the aggregate in the case of any such secured note, the amount of unpaid principal thereof; but no value shall be claimed or will be allow d for shares of stock of the reporting insurer's own issue pledged as such security.

§ 2286. Real Estate: Property Used in Business.

Real property requisite for the accommodation of the reporting insurer in the transaction of its business shall not be valued in excess of the cost thereof plus the cost of capitalized improvements, less normal depreciation.

§ 2287. Other Real Property.

All other real property not under contract of sale shall be valued as follows:

(a) Real property acquired by foreclosure or in the satisfaction of debt shall be valued at an amount not to exceed the smaller of the following: Cost plus the cost of capitalized improvements, less normal depreciation, or market value as evidenced by a current appraisal by a competent and qualified appraiser.

(b) Real property acquired for investment purposes shall be valued at an amount not to exceed the smaller of the following: Cost plus the cost of capitalized improvements, less normal depreciation, or market value as evidenced by a current appraisal by a competent and qualified appraiser.

HISTORY

1. Amendment filed 6-13-68; effective thirtieth day thereafter (Register 68, No. 22).
2. Amendment filed 2-7-69 as an emergency; designated effective 2-7-69 (Register 69, No. 6).

§ 2288. Appraisal: When Required.

The appraisal of real estate may be made, if and when, on the basis of net earnings, it is indicated that property may be worth substantially less than cost plus the cost of capitalized improvements, less normal depreciation. In determining such net income, a rental charge or estimate by the owner for its own occupancy of all or part of such real property shall be limited to a reasonable amount with due regard to what a willing tenant other than the owner would pay in a free market.

HISTORY

1. Amendment filed 6-13-68; effective thirtieth day thereafter (Register 68, No. 22).
2. Amendment filed 2-7-69 as an emergency; designated effective 2-7-69 (Register 69, No. 6).

§ 2289. Property Under Contract of Sale.

Real property under contract of sale shall be valued at an amount not in excess of the lowest of the following:

(a) The reasonable value thereof on December 31.

(b) The cost of acquisition, increased by so much of the book profit if any, involved in the sale price, as will bear to the total book profit the same proportion that payments received on account of the sale price bear to the total sale price.

(c) The unpaid principal of such several contracts of sale without addition of interest in arrears or accrued and without addition of advances made.

Advances made on such contracts must not be listed elsewhere as assets unless deducted as "Assets Not Admitted." Interest on such contracts which is in arrears shall not, unless also deducted under "Assets Not Admitted," be listed elsewhere as an asset; provided, however, if the balance

due, including interest, under any contract of sale is less than 66 2/3% of the value of the underlying real estate, then interest which is in arrears on any contract may be admitted as an asset but not in excess of one year's interest.

§ 2290. General: Basis of Valuation Must Be Reported in Annual Statement.

The basis of valuation used for each of the classes of securities and properties herein described must be clearly reported in the annual statement, which must be accompanied by the declaration of the reporting officer or officers of insurer, to the effect that, wherever "actual market value" or "reasonable values," as the case may be, as herein required to be reported, have been reported, they and the prescribed fractions thereof, as the case may be, have in each case been reported on the basis herein prescribed. Such declaration shall also state all cases in which a valuation

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of the basis herein prescribed is impossible, the reasons therefor, and shall describe the valuation actually used in such cases.

§ 2291. Adjustment of Values in Special Cases.

In cases where the conditions of insurance companies, societies and associations may require special consideration or the immediate disposal of assets, it shall be within the discretion of the Commissioner to vary the general procedures or formulas herein set forth to the extent deemed necessary, or to adopt prices reflected by the exchanges or markets.

Article 3. Annual Statements

PREMIUMS IN COURSE OF COLLECTION

§ 2300. Premiums in Course of Collection: When May Be Treated as Admitted

For purposes of the Annual Statement required of insurers to be filed with the Insurance Commissioner of the State of California on or before March 1 of the current calendar year, the following Premiums in Course of Collection may be treated as "Admitted Assets":

(a) Premiums in course of collection, other than life insurance and annuity premiums, and not more than 3 months past due on December 31 of the preceding calendar year.

(b) Premiums in course of collection, other than life insurance and annuity premiums, for which the Government of the United States or any of instrumentalities is directly liable to the insurer, whether or not more than 3 months past due on December 31 of the preceding calendar year.

All other Premiums in Course of Collection on December 31 of the proceeding calendar year shall be reported and will be treated as "Assets Not Admitted" unless provided otherwise in the Instructions relating to the completion of annual and quarterly statements.

All annual and quarterly statements must be completed in full compliance with the instructions attached thereto and set forth therein.

NOTE: Authority cited for 2300 to 2301; Sections 923 and 12921, Insurance Code.

HISTORY

1. Amendment filed 5–30–74 as procedural and organizational; effective upon filing (Register 74, No. 22.)

§ 2301. Schedule F, Life Statement.

All insurers authorized to transact life insurance or life and disability insurance in the State of California are hereby required hereafter to list in Schedule F, irrespective of the presence or absence of litigation, all claims in fact resisted or compromised during the year covered by the annual statement of which such Schedule F is a part, and all claims remaining resisted at the end of such year.

§ 2302. Method of Reporting Salvage or Subrogation Recoveries on Annual or Interim Financial Statements.

For purposes of the Annual Statement required of insurers to be filed with the Commissioner on or before the first day of March of each year or any interim financial statement filed with the Commissioner during the year by an insurer, anticipated salvage recoveries or anticipated subrogation recoveries shall have been reduced to cash or any asset readily convertible to cash.

NOTE: Authority cited: Sections 923 and 12921, Insurance Code. Reference: Section 907, Insurance Code.

HISTORY

1. New section filed 11–17–76; effective thirtieth day thereafter (Register 76, No. 47).

§ 2303. Reinsurance Accounting, Agreements and Oversight.

Sections 2303 through 2303.25 of this article set forth the principal requirements of substance and procedure in accounting for reinsurance on insurer financial statements, the general requirements applicable to reinsurance agreements, and related sanctions and oversight. The sections are applicable to all insurers licensed or accredited in California, the approved U.S. trusts of otherwise unauthorized reinsurers, and licensed reinsurance intermediaries. The sections may be referred to as the Reinsurance Oversight Regulations.

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 923, 924, 1011.5, 1215.8, 1781.12 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 900, 922.1, 922.2, 922.3, 922.4, 922.5, 922.6, 922.7, 922.8, 922.9, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f), 1781.10 and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.1. Purpose.

Sections 2303 through 2303.25 of this article set forth requirements for the proper and uniform preparation by licensed insurers of the financial statements required by the California Insurance Code and the requirements for acceptable reinsurance arrangements. The requirements are intended to elicit from insurers a true exhibit of their financial condition and to safeguard the solvency of licensees. The sections give notice as to the manner in which the Commissioner will exercise the discretion set forth in Code Sections 700, 701, 704, 717, 730, 733, 922.2 through 922.8, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f), 1781.10, and Section 12921 of the Code as respects accounting for reinsurance in insurer financial statements, acceptable reinsurance arrangements, and regulatory oversight. All statutory references are to the California Insurance Code ("Code") unless otherwise stated.

The duties and the discretion of the Insurance Commissioner conferred by statute to ensure proper accounting for reinsurance and oversight of reinsurance arrangements are not exhausted by these regulations.

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 923, 924, 1011.5, 1215.8, 1781.12 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 900, 922.1, 922.2, 922.3, 922.4, 922.5, 922.6, 922.7, 922.8, 922.9, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f), 1781.10 and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.2. Definitions.

As used in this article:

(a) "Accredited reinsurer" means an insurer that has been accredited pursuant to Code Section 922.4(b) and Section 2303.4 of this article.

(b) "Alien insurer" means an insurer organized under the laws of any jurisdiction other than a State of the United States.

(c) "Approved U.S. trust" or "U.S. trust" means the multiple beneficiary trust established by an insurer or group of insurers to secure obligations under reinsurance agreements, that has been approved pursuant to the provisions of Code Section 922.4(c) and Section 2303.5 of this article.

(d) "Assuming insurer" or "reinsurer" means the insurer to which risk is transferred under a reinsurance agreement.

(e) "Ceding insurer" means the insurer that transfers risk to another insurer under a reinsurance agreement.

(f) "Commissioner" means the California Insurance Commissioner.

(g) "Department" means the California Department of Insurance.

(h) "Domestic insurer" means a licensed insurer domiciled in this state.

(i) "Domestic ceding insurer" means a domestic insurer that is a ceding insurer.

(j) "Examine" or "examination" as used in Code Section 730 includes an examination or review of any nature, scope or frequency by the Department of a licensed insurer, regardless of the location of the review or examination.

(k) "Financial statements" mean the statements and reports of an insurer filed with the Commissioner for the purpose of exhibiting the insurer's financial condition and affairs.

(*l*) "Foreign ceding insurer" means a foreign insurer that is a ceding insurer.

(m) "Foreign insurer" means a licensed insurer domiciled in another state.

(n) "Insurer" includes "reinsurer" unless otherwise apparent from the context.

(o) "Licensed insurer" means an insurer that has been issued a Certificate of Authority permitting it to transact insurance business in this state.

(p) "NAIC" means the National Association of Insurance Commissioners.

(q) "NAIC Accounting Guidance" means the NAIC Accounting Practices and Procedures Manual and the NAIC annual statement blanks and instructions, as amended from time to time, as made applicable to licensed insurers pursuant to Code Section 923.

(r) "RBC Report" means the Risk Based Capital report required of domestic insurers by Code Section 739.2, and of foreign insurers by their state of domicile.

(s) "Regulatory oversight" means the exercise of any or all powers granted a regulator to monitor or control the operations of an insurer; oversight may be formal, informal or voluntary. As used in this article, regulatory oversight means any of those actions taken by a regulator in response to a hazardous financial condition of an insurer. Regulatory oversight may be preliminary in nature, such as a determination to include a licensee on a regulator's watch list.

(t) "Reinsurance contract" or "reinsurance agreement" or "reinsurance treaty" means a contract by which an insurer transfers to another insurer all or part of its risk on business it has directly written or assumed.

(u) "Reinsurance intermediary" or "intermediary" means a licensed reinsurance intermediary–broker or a licensed reinsurance intermediary–manager, as defined in Code Section 1781.2.

(v) "Unauthorized reinsurer" means a reinsurer that is not licensed nor accredited in this state, and that does not maintain an approved U.S. trust.

(w) "Volume insurer" means any foreign insurer whose average gross direct premiums written in California as reported in its three most recent annual statements, or as reported for any lesser period of time if it has been licensed in California only for such lesser period of time, (a) exceeds the average gross direct premiums written in its state of domicile for the same period, and (b) constitutes 33 percent or more of its total gross direct premiums written in the United States for such three year or lesser period.

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 923, 924, 1011.5, 1215.8, 1781.12 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 900, 922.1, 922.2, 922.3, 922.4, 922.5, 922.6, 922.7, 922.8, 922.9, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f), 1781.10 and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.3. Credit for Reinsurance Ceded to Admitted Insurer.

Credit on financial statements shall be allowed for reinsurance ceded to an assuming insurer that was licensed in California as of the date on which statutory financial statement credit for reinsurance is claimed, unless (1) the assuming insurer is the subject of a regulatory order or regulatory oversight on the grounds of hazardous financial condition by any state in which it is licensed, (2) the cession is not in compliance with the applicable provisions of Sections 2303.11 through 2303.13 of this article, or (3) the assuming insurer was not licensed or otherwise permitted to write or assume the lines or classes of business in its state of domicile.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3, 922.4, 922.6 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.4. Credit for Reinsurance Ceded to Accredited Reinsurer.

(a) Credit on financial statements shall be allowed for reinsurance ceded to an assuming insurer that is an accredited reinsurer in California as of the date on which statutory financial statement credit for reinsurance is claimed, unless (1) the assuming insurer is the subject of a regulatory order or regulatory oversight on the grounds of hazardous financial condition by any state in which it is licensed, (2) the cession is not in compliance with the applicable provisions of Sections 2303.11 through 2303.13 of this article, or (3) the assuming insurer was not licensed or otherwise permitted to write or assume the lines or classes of business in its state of domicile.

(b) A reinsurer seeking accreditation shall file an application with the Commissioner that must include:

1. An executed Certificate of Assuming Insurer Form AR–1, published in Section 2303. 25(a) of this article, wherein the reinsurer:

A. Submits to the authority of the Commissioner to examine its books and records, and agrees to bear the expense of such examination or examinations; and

B. Affirms it has attached to such Certificate a current list of its ceding insurers domiciled in California, and undertakes to submit to the Commissioner additions to or deletions from such list at least once per calendar quarter.

2. An executed Designation of Agent for Service of Process and Consent to Jurisdiction Form AR–2, published in Section 2303. 25(b) of this article;

3. A certified copy of a certificate of authority or other acceptable evidence of a license to transact insurance or reinsurance in at least one state;

4. A statement, verified by an officer of the reinsurer, disclosing whether the reinsurer, or any affiliated person with an interest of 10% or more in the reinsurer, is currently known to be the subject of any order or proceeding initiated by a regulator in any jurisdiction regarding (1) conservation, liquidation or receivership, (2) revocation or suspension of a license or accreditation, or (3) restricting or precluding the transaction of insurance based upon a hazardous financial condition. Where the regulatory action is confidential, disclosure to the Commissioner is required only if permitted by the regulator issuing the order or initiating the oversight. The statement shall affirm that no actions, proceedings or orders subject to disclosure by this paragraph are outstanding, except as disclosed in the statement. The reinsurer shall attach to the statement copies of orders and other documents initiating proceedings for matters disclosed in the statement. The statement shall be in a form acceptable to the Commissioner.

5. A copy of the reinsurer's:

A. Annual financial statements for the past 3 years and all quarterly financial statements filed since the most recent annual statement, if any. The annual statements, including any amendments and NAIC required attachments, shall be signed and verified by the reinsurer's principal executive officer or manager residing within the United States. ;

B. Most recent examination report, with an "as of" date of not more than 5 years prior to its submission;

C. Most recent independent audit report and report of internal controls, with an "as of" date of not more than 15 months prior to its submission;

D. Most recent 8–K, 10–K and 10–Q forms, if any, filed with the SEC by the applicant or any controlling person;

E. Certificate of good standing from its state of domicile, or from the state of an alien insurer's port of entry;

F. Most recent holding company registration statement and any supplements thereto filed with its state of domicile;

G. Most recent RBC report; and

H. News releases issued by or on behalf of the reinsurer within the year prior to submission.

6. Additional information or documentation as requested by the Commissioner.

(c) To retain eligibility as an accredited reinsurer, the reinsurer shall:

1. File its quarterly and annual financial statements and its RBC report at the same time those documents are filed with its state of domicile;

2. File an updated list of domestic insurer cedants quarterly;

3. File copies of news releases as they are issued by or on behalf of the reinsurer; by prior arrangement with the Department, such filings may be made electronically; and

4. File, on or before August 15 of each year, the documents required by subdivision (b) of this section, except that it is not necessary to file duplicates of financial documents and press releases already submitted.

(d) The costs and expenses incurred by the Department to review a reinsurer's application for accreditation and subsequent filings shall be charged to and collected from the reinsurer. The application for accreditation and required filings shall be submitted in the manner set forth in Section 2303.22(c) of this article.

(e) An accredited reinsurer, authorized under Code Section 922.4(b) for the specific purpose of permitting statement credit for a cession by a licensed insurer without the security required by Code Section 922.5, is not a licensed insurer and may not solicit or transact insurance business in this state either directly or through an agent or reinsurance intermediary acting on its behalf.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3, 922.4, 922.6 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.5. Credit for Reinsurance Secured by an Approved U.S. Trust.

(a) Credit on financial statements shall be allowed for reinsurance ceded to an assuming insurer that, as of any date on which statutory financial statement credit for reinsurance is claimed and thereafter for so long as credit for reinsurance is claimed, maintains an approved U.S. trust as security for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest, unless the cession is not in compliance with the applicable provisions of Sections 2303.11 through 2303.13 of this article. As used in this section, "assuming insurer" includes all categories of insurers described in Code Section 922.4(c)(4).

(b) An assuming insurer seeking approval of a U.S. trust under Code Section 922.4(c) may file an application with the Commissioner in the manner set forth in Section 2303.22(d) of this article. The application shall include:

1. A copy of the trust document, certified by the commissioner of the Oversight State. As used in this section, "Oversight State" means the state where the trust is domiciled or the state whose commissioner has accepted principal regulatory oversight of the trust pursuant to the terms of the trust agreement;

2. A certified copy of the approval of the form of the trust issued by the commissioner of the Oversight State;

3. An independent audit report;

4. An actuarial opinion;

5. Copies of all documents submitted to the Oversight State, unless the Commissioner has agreed that copies of specified documents need not be provided;

6. An executed Certificate of Assuming Insurer Form AR–1, published in Section 2303. 25(a) of this article, wherein the assuming insurer:

A. Submits to the authority of the Commissioner to examine its books and records, and agrees to bear the expense of any such examination; and

B. Affirms it has attached to the Certificate a current list of its ceding insurers domiciled in California, and undertakes to submit additions to or deletions from the list to the Commissioner at least once per calendar quarter, unless, for good cause shown, the Commissioner permits a different reporting interval for additions to or deletions from the list;

7. An executed Designation of Agent for Service of Process and Consent to Jurisdiction Form AR–2, published in Section 2303. 25(b) of this article; and

8. Any other documents requested by the Commissioner.

(c) The form of a trust reviewed under this section shall not be acceptable to the Commissioner unless it (1) meets the requirements of Code Sections 922.4(c)((3) and 922.4(f), (2) meets the requirements of subdivision (f) of this section if the assets of the trust include a letter of credit, and (3) provides that the trustee shall be liable for its negligence or willful misconduct.

(d) A trust shall not be deemed sufficient by the Commissioner unless it (1) is in the amount prescribed in Code Section 922.4(c)(4), (2) is held in a U.S. financial institution which meets the requirements of Code Section 922.7, and (3) consists of assets meeting the requirements of this section. Assets equal to liabilities shall be on deposit in the trust no later than 45 days after the end of each calendar quarter unless the Commissioner determines that, for good cause shown, a reasonable extension of time to fund the deposit should be granted. Trust assets shall consist only of cash in United States dollars, certificates of deposit issued by a United States financial institution as defined in Code Section 922.7(a), investments as permitted in subdivision (e) of this section, or letters of credit as permitted in subdivision (f) of this section.

(e) In determining the sufficiency of the trust, only the following investments may be considered, according to their fair market value:

1. Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:

A. The United States or by any agency or instrumentality of the United States;

B. Any state of the United States;

C. A territory, possession or other governmental unit of the United States;

D. An agency or instrumentality of a government unit referred to in subparagraphs (B) and (C) of this paragraph, if the obligations are by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of making these payments, but not including obligations payable solely out of special assessments on properties benefited by local improvements; or

E. The government of any other country that is a member of the Organisation for Economic Co–Operation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

2. Obligations that are issued in the United States, or that are dollar–denominated and issued in a non–U.S. market, by a solvent United States institution (other than an insurance company) or that are assumed or guaranteed by a solvent United States institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

A. Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated; or

B. Are insured by at least one authorized insurer (other than the investing insurer or parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or

C. Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;

3. Obligations issued, assumed or guaranteed by a solvent non–United States institution chartered in a country that is a member of the Organisation for Economic Co–Operation and Development or obligations of U.S. corporations issued in a non–U.S. currency, provided that in either

case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

4. An investment made pursuant to the provisions of paragraphs (e)(1), (e)(2) or (e)(3) of this section shall be subject to the following additional limitations:

A. An investment in or loan upon the obligations of any one institution, other than an institution that issues mortgage–related securities, shall not exceed five percent (5 %) of the assets of the trust;

B. An investment in any one mortgage–related security shall not exceed five percent (5 %) of the assets of the trust;

C. The aggregate total investment in mortgage–related securities shall not exceed twenty–five percent (25 %) of the assets of the trust; and

D. Preferred or guaranteed shares issued or guaranteed by a solvent United States institution are permissible investments if all of the institution's obligations are eligible as investments under subparagraphs (e)(2)(A) and (e)(2)(C) of this section, but shall not exceed two percent (2%) of the assets of the trust;

5. As used in this subdivision:

A. "Mortgage–related security" means an obligation that is rated AA or higher (or the equivalent thereto) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and:

i. Represents ownership of one or more promissory notes or certificates of interest or participation in such notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of such notes, certificates, or participation of amounts payable under such notes, certificates or participation), which notes:

a. Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

b. Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Sections 1709 and 1715b, or, where such notes involve a lien on the manufactured home, by any such institution or by any financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. section 1703; or

ii. Is secured by one or more promissory notes or certificates of deposit or participation in such notes (with or without recourse to the insurer thereof) and, by its terms, provides for payments of principal in relation to payments or reasonable projections of payments, or notes meeting the requirements of subitems (e)(5)(A)(i)(a) and (e)(5)(A)(i)(b) of this section.

B. "Promissory note", when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument;

6. Investments in common shares or partnership interests of a solvent United States institution are permissible if:

A. Its obligations and preferred shares, if any, are eligible as investments under subdivision (e) of this section; and

B. The equity interests of the institution (except an insurance company) are registered on a national securities exchange, as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a to 78kk or otherwise registered pursuant to that Act, and, if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the National Association of Securities Dealers, Inc. A trust shall not invest in equity interests under paragraph (e)(6) of this section in an amount exceeding one percent (1 %) of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company;

7. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development are permissible if:

A. All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

B. The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;

8. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

9. Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U. S.C. § 80a, are permissible investments if the investment company:

A. Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under paragraphs (e)(1), (e)(2) or (e)(3) of this section; or that invests in securities that are determined by the Commissioner to be substantively similar to the permitted securities; or

B. Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under paragraph (e)(6) of this section;

10. An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent (1 %) of the assets of the trust;

11. Investments in an investment company qualifying under subparagraph (e)(9)(A) of this section shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investments in such investment companies shall not exceed twenty–five percent (25 %) of the assets in the trust. Investments in an investment company qualifying under subparagraph (e)(9)(B) of this section shall not exceed five percent (5 %) of the assets in the trust;

12. The aggregate investment in equity interests permitted under paragraphs (e)(6) and (e)(7) and subparagraph (e)(9)(B) of this section shall not exceed ten percent (10%) of the assets in the trust;

13. Investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5 %) of total investments; and

14. No more than twenty percent (20%) of the total of the investments in the trust may be the foreign investments authorized under subparagraph (e)(1)(E), paragraph (e)(3), subparagraph (e)(6)(B) or paragraph (e)(7) of this section, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in United States dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency.

(f) In the determination of whether a trust is sufficient to cover the assuming insurer's liabilities, a letter of credit issued by a United States financial institution as defined in Code Section 922.7(a) may be considered, in an amount not to exceed twenty percent (20%) of the assets in the trust. In order for a letter of credit to qualify as an asset of a trust reviewed under this section the trust agreement shall provide that:

1. The trustee shall have the right and the obligation to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced; and

2. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall constitute negligence and/or willful misconduct.

(g) In the determination of whether a trust is sufficient to cover the assuming insurer's liabilities, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by United

States domiciled insurers that are not otherwise secured by acceptable means, and shall include:

1. For business ceded by insurers authorized to write either disability, or property and casualty insurance, or both:

A. Losses and allocated loss expenses paid by the ceding insurer recoverable from the assuming insurer;

B. Reserves for losses reported and outstanding;

C. Reserves for losses incurred but not reported;

D. Reserves for allocated loss expenses; and

E. Unearned premiums.

2. For business ceded by insurers authorized to write life, disability and annuity insurance:

A. Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

B. Aggregate reserves for accident and health policies;

C. Deposit funds and other liabilities without life or disability contingencies; and

D. Liabilities for policy and contract claims.

As used in this subdivision, "disability" means the class of insurance defined in Code Section 106.

(h) If an assuming insurer provided security meeting the requirements of Sections 2303.7, 2303.8 or 2303.9 of this article, then exhaustion of that security is a condition precedent to presentation of a claim by the ceding insurer for payment by a trustee of a U.S. trust established by the assuming insurer. The condition precedent shall be deemed satisfied if security held under Section 2303.9 of this article has been exhausted, and a demand for payment of the security established by the assuming insurer under Section 2303.7 or 2303.8 of this article has not been met within sixty (60) days of the demand.

(i) The Commissioner shall designate a trust meeting the requirements of this section as an approved U.S. trust. To retain eligibility of the trust, the assuming insurer shall file its annual and quarterly financial statements, trust statements, and lists of ceding insurers with the Commissioner at the same time such filings are made with the Oversight State. Not later than February 28 of each year, the assuming insurer shall file the trustees' report required by Code Section 922.4(c)(3)(E). Not later than August 15 of each year, the assuming insurer shall file the documents required in subdivision (b) of this section in the manner provided in Section 2303.22(d), except that it is not necessary to file duplicates of financial documents already submitted. Alien insurers shall include in the annual filings all reports required by their domiciliary countries.

(j) Pursuant to Section 922.4(c)(5) of the Code, the costs and expenses incurred by the Department to review the trust documents, reports, subsequent amendments, and periodic filings shall be charged to and collected from the assuming insurer.

(k) An assuming insurer, authorized under Code Section 922.4(c) for the specific purpose of permitting statement credit for a cession by a licensed insurer without the security otherwise required of the reinsurer by Code Section 922.5, is not a licensed insurer and may not solicit or transact insurance business in this state either directly or through an agent or reinsurance intermediary acting on its behalf.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3, 922.4, 922.6 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.6. Credit for Reinsurance Required by Law.

As used in Code Section 922.4(d), "jurisdiction" means a state, district or territory of the United States.

NOTE: Authority cited: Section 922.8, Insurance Code. Reference: Section 922.4(d), Insurance Codee.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.7. Credit for Reinsurance Secured by a Single Beneficiary Trust.

(a) Credit on financial statements of a domestic insurer shall be allowed for reinsurance ceded to an assuming insurer to the extent of funds held in a trust acceptable to the Commissioner for the exclusive benefit of the ceding insurer as security for the payment of obligations under the reinsurance contract, unless the cession is not in compliance with this section and the applicable provisions of Sections 2303.11 through 2303.13 of this article. The amount of the credit shall not exceed the liabilities carried by the ceding insurer.

(b) As used in this subdivision:

1. "Beneficiary" means the domestic insurer for whose sole benefit the trust has been established, and includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.

2. "Grantor" means the insurer that has established the trust for the sole benefit of the beneficiary.

3. "Trustee" means a qualified United States financial institution as defined in Section 922.7(b) of the Code.

(c) A trust naming a domestic insurer as beneficiary shall not be acceptable to the Commissioner unless it meets all of the following requirements:

1. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee.

2. The trust agreement shall create a trust account into which assets shall be deposited.

3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except those assets held in book–entry form;

4. The trust agreement shall provide that:

A. The beneficiary shall have the right to withdraw assets from the trust account at any time, without prior notice to the grantor, subject only to written notice from the beneficiary to the trustee;

B. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets; and

C. It is not subject to any conditions or qualifications outside of the trust agreement.

5. The trust agreement shall be established for the sole benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

A. Receive and hold all assets in a safe place;

B. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

C. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

D. Notify the grantor and the beneficiary within ten (10) business days, of any deposits to or withdrawals from the trust account;

E. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver custody of the assets to the beneficiary; and

F. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

7. The trust agreement shall provide that at least thirty (30) days, but not more than forty–five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary by registered or certified mail, return receipt requested, or by overnight courier service, signature upon delivery required.

8. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

9. The trust agreement shall provide that the trustee shall be liable for its own negligence or willful misconduct.

10. The trust agreement shall not contain references to any other agreements or documents.

(d) An acceptable trust agreement naming a domestic insurer as beneficiary may contain the following provisions:

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

2. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

3. The trust agreement may provide that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Code or any combination of the above; and may further provide that investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments.

4. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in paragraph (d)(3) of this section.

5. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

6. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

7. The trust agreement may be made subject to and governed by the laws of the state in which the trust is domiciled.

(e) The trust securing the reinsurance agreement of a domestic ceding insurer shall not be acceptable unless the reinsurance agreement:

1. Provides that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States financial institution as defined in Code Section 922.7(a) and payable in United States dollars, and investments permitted by the California Insurance Code, or any combination of the above.

2. Provides that investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments.

3. Requires the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may, whenever necessary, negotiate these assets without consent or signature from the assuming insurer or any other entity.

4. Provides that assets in the trust account shall be withdrawn only as permitted in the reinsurance agreement, without diminution because of the insolvency of the ceding insurer or the assuming insurer.

(f) A reinsurance agreement of a domestic ceding insurer secured by the trust permitted under this section may:

1. Require the assuming insurer to enter into a trust agreement to establish a trust account for the benefit of the ceding insurer, and specify what the trust agreement is to cover.

2. Require, when the trust is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

A. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

B. To make payment to the assuming insurer of any amounts held in the trust account that exceed one hundred and two percent (102%) of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement;

C. To pay any other amounts necessary to secure the credit or deduction from liability for reinsurance taken by the ceding insurer; or

D. Where the ceding insurer has received notification of termination of the trust and where any of the assuming insurer's obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account in the name of the ceding insurer in any qualified United States financial institution as defined in Code Section 922.7(b) apart from its general assets, in trust for such uses and purposes specified in subparagraphs (f)(3)(A) and (f)(3)(B) of this section as may remain executory after such withdrawal and for any period after the termination date.

E. "Obligations" as used in this paragraph means:

i. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

ii. Reserves for reinsured losses reported and outstanding;

iii. Reserves for reinsured losses incurred but not reported; and

iv. Reserves for reinsured allocated loss adjustment expenses and unearned premiums.

3. Require, when a trust is established to meet the requirements of Code Section 922. 5 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

A. To pay or reimburse the ceding insurer for:

i. The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies, and

ii. The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

B. To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or deduction from liability for reinsurance taken by the ceding insurer;

C. To pay any other amounts necessary to secure the credit or deduction from liability for reinsurance taken by the ceding insurer; or

D. Where the ceding insurer has received notification of termination of the trust and where any of the assuming insurer's obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in subparagraphs (f)(4)(A) and (f)(4)(B) of this section as may remain executory after withdrawal and for any period after the termination date.

4. Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

A. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or

B. After withdrawal and transfer, the market value of the trust account is no less than one hundred and two percent (102%) of the required amount.

The ceding insurer shall not unreasonably withhold its approval.

5. Provide for the return of any amount withdrawn in excess of the actual amounts required for paragraphs (f)(2) or (f)(3) of this section, and for interest payments at a rate not in excess of the prime rate of interest on the amounts held pursuant to paragraphs (f)(2) or (f)(3) of this section.

6. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent.

7. Permit the award by any arbitration panel or court of competent jurisdiction of:

A. Interest at a rate different from that provided in paragraph (f)(5) of this section,

B. Court or arbitration costs,

C. Attorney's fees, and

D. Other reasonable expenses.

(g) A trust in compliance with the provisions of this section may be used by a domestic insurer to reduce any liability for reinsurance ceded to an unauthorized reinsurer in financial statements required to be filed with this Department, when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust was established to secure.

(h) The failure of any trust agreement or trust account established for the benefit of a domestic insurer to specifically identify the beneficiary as defined in Section 2303.7(b) of this article shall not be construed to affect any actions or rights which the Commissioner may take or possess pursuant to the provisions of the laws of this state.

(i) A denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of this article.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3, 922.5 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.8. Credit for Reinsurance Secured by Letter of Credit.

(a) Credit on financial statements of a domestic insurer shall be allowed for reinsurance ceded to an assuming insurer, in an amount not exceeding the liabilities carried by the ceding insurer, to the extent that security is provided by a letter of credit satisfactory to the Commissioner, unless the cession is not in compliance with the applicable provisions of Sections 2303.11 through 2303.13 of this article.

(b) As used in this section:

1. "Beneficiary" means the domestic insurer for whose sole benefit the letter of credit has been established by an issuing or confirming bank, and includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver or conservator.

2. "Applicant" means the reinsurer that applies for and causes the letter of credit to be issued.

(c) A letter of credit naming a domestic insurer as beneficiary shall not be satisfactory to the Commissioner unless it meets the following requirements:

1. The letter of credit shall be issued or confirmed by a qualified United States financial institution as defined in Code Section 922.7(a).

2. The letter of credit shall state that it is irrevocable and unconditional, and shall:

A. Contain no extraneous language or reference to any other agreements, documents or entities.

B. Provide that, except where the amount of the letter of credit is increased, the letter cannot be modified without the prior written consent of the beneficiary.

C. Provide that the obligation of the issuing or confirming bank is not contingent upon reimbursement or its ability to perfect a lien or obtain a security interest.

3. In order to draw funds, the letter of credit shall require only the presentation of a sight draft indicating the credit number.

4. The letter of credit shall contain an issue date and an expiration date.

5. The letter of credit shall be for a term of not less than one year.

6. The letter of credit shall contain an "evergreen" clause which provides that the term of the letter shall extend automatically without amendment for the same term as the original letter, unless at least sixty (60) days prior to the expiration date, a notice of non–renewal is sent to the beneficiary by registered or certified mail, return receipt requested, or by overnight courier service, signature upon delivery required.

7. The letter of credit shall state the address of the issuing bank or confirming bank where the letter is issued or confirmed, where it is payable, and where drafts may be presented for payment. The letter may also permit the presentation of sight drafts at other designated offices.

8. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 500), or any successor publication, then the letter of credit shall specifically provide for a period of not less than sixty (60) days after the resumption of business to draw against the letter of credit in the event that one or more of the occurrences specified in Article 17 of Publication 500, or any successor publication, occur causing interruption of the business of the bank or of the beneficiary.

9. If the letter of credit is not made subject to the publication referenced in paragraph (c)(9) of this section, the letter shall provide for a period of not less than sixty (60) days after resumption of business to draw against the letter of credit in the event of an interruption of the business of the bank or of the beneficiary caused by an Act of God, riot, civil commotion, insurrection, war, terrorism or any other cause beyond control or by any strike or lockout.

10. If the letter of credit is more than one page, each page shall identify the issuing bank and the credit number.

11. The heading of the letter of credit may include a boxed section containing the name of the applicant, the beneficiary's name and state of domicile, and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(d) An optional form that meets the letter of credit requirements of this section is provided in Section 2303.25(d) of this article. A written determination that an alternate form meets the requirements of this section may be made in the manner set forth in Section 2303.22(e) of this article.

(e) A reinsurance agreement entered in conjunction with a letter of credit naming a domestic insurer as beneficiary may contain provisions that:

1. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

2. Stipulate that the assuming insurer and ceding insurer agree that a letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

A. To pay or reimburse the ceding insurer for:

i. The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

ii. The assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

iii. Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

B. To secure payment of the assuming insurer's obligations where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's obligations under the reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the expiration date, by withdrawing amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and depositing those amounts in a separate account in the name of the ceding insurer in a qualified United States financial institution as defined in Code Section 922.7(b) apart from its general assets, in trust for such uses and purposes specified in subparagraph (f)(2)(A) of this section as may remain after withdrawal.

3. Provide for an interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to paragraph (f)(2) of this section; or the return of any amounts drawn down on the letters of credit in excess of any amounts that are subsequently determined not to be due.

(f) A denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of this article.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3, 922.5 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.9. Credit for Reinsurance Secured by Funds Withheld.

(a) Credit on financial statements of a domestic insurer shall be allowed for reinsurance ceded to an unauthorized reinsurer, in an amount not exceeding the liabilities carried by the ceding insurer, to the extent of unencumbered funds withheld by the ceding insurer as security for payment of the reinsurer's obligations under the reinsurance agreement, unless the cession is not in compliance with applicable requirements of Sections 2303.11 through 2303.13 of this article.

(b) As used in subdivision (a) of this section, "unencumbered funds withheld" means funds that are held in the United States solely in the name of and under the exclusive control of the ceding insurer. For purposes of this section, "exclusive control of the ceding insurer" includes (1) funds held in an escrow or trust account where the ceding insurer has the sole right to withdraw assets from the account at any time and without prior notice to the reinsurer, and (2) funds held in an escrow or trust account to secure a cession to an affiliate. The agreement establishing the escrow or trust account shall be in a form satisfactory to the Commissioner.

(c) A denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of this article.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3, 922.5 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.10. Credit for Reinsurance of Foreign Insurers.

(a) Credit for reinsurance shall not be allowed a foreign insurer for an agreement not in compliance with the applicable requirements of Sections 2303.11, 2303.12 and 2303.13 of this article and the requirements of Code Section 923.

(b) Credit for reinsurance meeting the requirements of subdivision (a) of this section shall be allowed to the extent that credit is allowed by the foreign insurer's state of domicile, unless the Commissioner has made the finding permitted by Code Section 922.6(b).

(c) If the Commissioner has reason to question a claim for statement credit and elects to review the claim pursuant to the provisions of Code Section 922.6(b), a foreign insurer shall provide all information and documentation as may be requested. If the information and documentation submitted by the foreign insurer does not establish to the Commissioner's satisfaction that the requirements of subdivision (d) of this section have been met, credit for the reinsurance shall be denied in the manner prescribed in Section 2303.19(c) of this article.

(d) Where credit is claimed on the basis that an unauthorized reinsurer is either licensed or accredited in the foreign insurer's state of domicile, the reinsurer must meet the financial standards for either licensing or accreditation in California. Where credit is claimed on the basis of security in the form of a trust agreement, letter of credit, or funds held agreement, the security must, in substance, meet the standards for like security in California.

(e) A foreign insurer shall pay the cost of examination of the documents and information it submits to the Department pursuant to subdivision (c) of this section.

NOTE: Authority cited: Sections 922.8 and 923, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.3, 922.6 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.11. Transfer of Risk — Life & Disability.

(a) This section prescribes accounting and other requirements for admitted life and disability insurers and for admitted property and casualty insurers with respect to their disability business. Failure to comply with this section results in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded, and, pursuant to Section 922.3 of the Code, the Commissioner shall not allow credit for such reinsurance.

(b) This section shall not apply to assumption reinsurance, or non–proportional reinsurance such as stop loss or catastrophe reinsurance. Except as provided in the Statutory Account Principles ("SSAP") 61 of the NAIC Accounting Guidance, it shall also not apply to yearly renewable term reinsurance ("YRT"), as described in SSAP 61, that provides reserve credit not greater than up to one year's valuation mortality cost.

(c) No insurer shall, for reinsurance ceded, reduce any liability or establish any asset in any statutory financial statement if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

1. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured.

2. The ceding insurer can be deprived of surplus or assets at the reinsurer's option, at a specified time scheduled in the reinsurance agreement, or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

3. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience.

4. The ceding insurer must, at specific points in time scheduled in the agreement or at the reinsurer's option, terminate or automatically recapture all or part of the reinsurance ceded.

5. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company.

6. The treaty does not transfer all of the significant risks inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business, the risks which are typically considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Table of Significant Risks

Risk Categories:
i. Morbidity
ii. Mortality
iii. Lapse
This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.
iv. Credit Quality
This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.
v. Reinvestment
This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.
vi. Disintermediation
This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

+ – Significant 0 – Insignificant

	Risk Category					
	i.	*ii.*	*iii.*	*iv.*	*v.*	*vi.*
Health Insurance — other than LTC/LTD*	+	0	+	0	0	0
Health Insurance — LTC/LTD *	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non–Par Permanent	0	+	+	+	+	+
Traditional Non–Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium (dump–in premiums allowed)	0	+	+	+	+	+

*LTC = Long Term Care Insurance
LTD = Long Term Disability Insurance

7. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the Commissioner which segregates, by contract or contract provision, the underlying assets. Assets held to secure statement credit for a cession to an unauthorized reinsurer as permitted by Code Section 922.5(a)(1) may not be placed in a trust or escrow account unless

(1) the reinsurer is an affiliate of the ceding insurer, or (2) the agreement establishing the escrow or trust account provides that the ceding insurer has the sole right to withdraw assets from the account at any time and without prior notice to the reinsurer. The agreement establishing the escrow or trust account shall be in a form satisfactory to the Commissioner.

A. This paragraph shall not apply to the assets supporting the reserves for the following classes of business:

(i) Health Insurance — LTC/LTD
(ii) Traditional Non–Par Permanent
(iii) Traditional Par Permanent
(iv) Adjustable Premium Permanent
(v) Indeterminate Premium Permanent
(vi) Universal Life Fixed Premium
(no dump–in premiums allowed)

B. When asset segregation is not required, the associated formula for determining the reserve interest rate adjustment shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2(I + CG)}{X + Y - I - CG}$$

Where:

I is the net investment income
CG is capital gains less capital losses
X is the current year cash and invested assets plus investment income due and accrued less borrowed money
Y is the same as X but for the prior year

8. Settlements are made less frequently than quarterly or amounts receivable from the reinsurer are not paid in cash within ninety (90) days of the settlement date.

9. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

10. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

11. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(d) Notwithstanding subdivision (c) of this section, the Commissioner may allow such reserve credit or establishment of such asset as the Commissioner considers appropriate. Such allowance shall not be deemed approval of the reinsurance treaty nor shall it be considered an indication that reinsurance credit may be allowed for other similar treaties.

(e) Any agreement entered into after the Effective Date of this section which involves the reinsurance of business issued prior to the effective year of the agreement, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days from its date of execution if such ceding company is domiciled in this state. Each such filing shall include data detailing the financial impact of the transaction. In the case of an agreement which was entered into prior to the Effective Date of this section but was subsequently amended on or after the Effective Date of this section, such agreement and amendment shall also be filed within 30 days from the date of execution of the amendment if such amendment added business issued prior to the effective year of the amendment and if the ceding company is domiciled in this state. The requirements of this subdivision are in addition to any other filings required by the Code or this article.

(f) Any increase in surplus net of federal income tax resulting from reinsurance agreements entered into or amended after the Effective Date of this section which involve the reinsurance of business issued prior to the effective date of the agreements shall be identified separately on the insurer's statutory financial statement as a surplus item and recognition of the surplus increase as income shall be reflected on a net of tax basis as earnings emerge from the business reinsured.

For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is $13.2 million ($20 million – $6.8 million) which is reported on the "Aggregate write–ins for gains and losses in surplus" line in the Capital and Surplus account. $6.8 million (34% of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

At the end of year N+1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66% of ($4 million – $1 million – $.5 million) up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and –$1.65 million on the "Aggregate write–ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.

(g) The ceding insurer's appointed actuary shall consider this section and any applicable actuarial standards of practice when determining the proper credit to take in financial statements filed with this Department. The appointed actuary should maintain adequate documentation and be prepared upon request to justify the inclusion of credit in the financial statement.

(h) If a letter of intent precedes the execution of a reinsurance agreement or amendment to a reinsurance agreement, then the agreement or the amendment must be executed within a reasonable period of time, not exceeding ninety (90) days from the execution date of the letter of intent.

(i) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

(j) The reinsurance agreement shall expressly state that it constitutes the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement. The entire agreement clause may provide that it shall not be construed to limit the admissibility of evidence regarding the formation, interpretation, purpose or intent of the reinsurance agreement.

(k) In the review of a reinsurance agreement to determine transfer of risk, all contracts between the ceding insurer, its affiliates and the reinsurer may, in the Commissioner's discretion, be reviewed.

(*l*) A denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of this article.

NOTE: Authority cited: Section 922.8, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.3 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.12. Transfer of Risk — Property & Casualty.

This section applies only to property and casualty insurance.

(a) Transfer of risk shall be determined by application of the risk transfer requirements of the NAIC Accounting Guidance. In the review of a reinsurance agreement to determine transfer of risk, all contracts between the ceding insurer, the reinsurer, and their respective affiliates, may, in the Commissioner's discretion, be reviewed to evaluate contractual features that may (1) limit the amount of insurance risk to which the reinsurer is subject under the agreement, or (2) delay the timely reimbursement of claims by the reinsurer.

(b) A denial of statement credit for failure of risk transfer shall be made in the manner prescribed in Section 2303.19(c) of this article.

NOTE: Authority cited: Section 922.8, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company*

v. Garamendi, 8 Cal. 4th 216 (1994). Reference: Sections 922.3 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.13. Contract Requirements for Statement Credit.

(a) Credit for reinsurance may be claimed only for an agreement that meets the requirements of this section.

(b) A reinsurance agreement of a domestic insurer or volume insurer ceding property and casualty business shall expressly state that it constitutes the entire agreement between the parties with respect to the business covered by the agreement, except for separate contracts expressly disclosed within the agreement or in an exhibit incorporated by reference. The entire agreement clause may provide that it shall not be construed to limit the admissibility of evidence regarding the formation, interpretation, purpose or intent of the reinsurance agreement.

(c) A volume insurer shall not be denied credit for a reinsurance agreement on the grounds of failure to comply with the requirements of subdivision (b) of this section if:

1. On the date of execution of a new or renewal agreement the insurer was not a volume insurer; or

2. The insurer was not a volume insurer in the year preceding the execution of a new or renewal agreement, and the agreement was executed within one hundred twenty (120) days of the "as of" date of the insurer's most recent annual statement.

(d) The agreement shall contain an acceptable insolvency clause. For a domestic insurer, the insolvency clause shall conform to the requirements of Code Section 922.2(a)(2). For a foreign insurer, the insolvency clause shall require, in substance, payment of the reinsurance by the reinsurer to the conservator, liquidator, rehabilitator or statutory successor, without diminution because of the insolvency of the ceding insurer, or because the conservator, liquidator, rehabilitator or statutory successor has failed to pay all or a portion of any claim. The insolvency clause may also provide that the conservator, liquidator, or statutory successor of a ceding insurer shall give written notice of the pendency of a claim against the ceding insurer indicating the policy or bond reinsured, within a reasonable time after such claim is filed and the reinsurer may interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defense or defenses which it may deem available to the ceding insurer or its conservator, liquidator, or statutory successor. The expense thus incurred by the reinsurer shall be payable subject to court approval out of the estate of the insolvent ceding insurer as part of the expense of conservation or liquidation to the extent of a proportionate share of the benefit which may accrue to the ceding insurer in conservation or liquidation, solely as a result of the defense undertaken by the reinsurer.

(e) The agreement shall meet the credit for reinsurance requirements of the NAIC Accounting Guidance that are not inconsistent with the requirements of this article.

(f) Reinsurance of individual risks pursuant to facultative certificates issued by the reinsurer shall not be required to comply with subdivision (b) of this section.

(g) A denial of statement credit shall be made in the manner prescribed in Section 2303.19(c) of this article.

NOTE: Authority cited: Section 922.8, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.2, 922.3 and 923, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.14. Form of Agreements.

(a) This section specifies contract provisions required to be included in a reinsurance contract for which a domestic insurer or a volume insurer claims statement credit. The failure to follow a requirement does not result in a denial of statement credit, but rather a determination that the reinsurance contract is deficient as to form. One or more reinsurance contracts that are deficient as to form may be sufficient to support a finding that the insurer's reinsurance arrangements are materially deficient for purposes of Code Section 700(c) and 717(d).

(b) A reinsurance contract shall be determined to be deficient as to form if it does not comply with each of the following requirements:

1. If an agreement contains an "early termination" provision wherein a party may terminate the agreement upon the occurrence of specified conditions, the following requirements apply to a termination by the reinsurer:

A. The basis for termination may not include the entry of an order of rehabilitation, conservation or liquidation against the ceding insurer.

B. The provision shall require written notice to the ceding insurer of not less than sixty (60) days prior to the effective date of termination,

C. The provision shall require signature upon delivery of the notice and may specify procedures to establish proof of attempted service if signature is refused.

D. The provision may state that upon receipt of a notice sent by the reinsurer, the ceding insurer may consent to a lesser notice period.

E. The provision may state that it shall not be construed to include termination of the contract for cause.

2. If the contract provides for payments between the parties to be transmitted through an intermediary, the contract shall include the following provision:

"Payments by [the ceding insurer] to the intermediary shall be deemed to constitute payment to (the reinsurer). Payments by (the reinsurer) to the intermediary shall be deemed to constitute payment to (the ceding insurer] only to the extent that such payments are actually received by (the ceding insurer]."

Notwithstanding this requirement, the parties to the reinsurance contract may agree therein that the reinsurer may make payment directly to the ceding insurer with notice of the payment sent to the intermediary.

(c) A reinsurance contract of a volume insurer is not deficient as to form on the grounds of failure to comply with the requirements of subdivision (b) of this section if:

1. On the date of execution of a new or renewal contract the insurer was not a volume insurer; or

2. The insurer was not a volume insurer in the year preceding the execution of a new or renewal contract, and the contract was executed within one hundred twenty (120) days of the "as of" date of the insurer's most recent annual statement.

(d) The reinsurance arrangements of a domestic or volume ceding insurer may be determined to be materially deficient for purposes of Code Section 700(c) and 717(d) if (1) the arrangements include one or more reinsurance contracts that are deficient as to form, and (2) the aggregate amount of business ceded by the deficient contracts is an amount that equals or exceeds 25% of either the total premium or total liabilities as reported on the ceding insurer's most recent financial statement. "Total premium" and "total liabilities" include both direct and assumed business. "Total liabilities" is defined in Section 2303.15(h) of this article.

(e) Reinsurance of individual risks pursuant to facultative certificates issued by the reinsurer shall not be required to comply with subdivision (b) of this section.

(f) Section 2303.14 of this article shall not be construed as stating the only bases for a determination by the Department that a reinsurance agreement is deficient as to form or the reinsurance arrangements of a licensed insurer are materially deficient.

NOTE: Authority cited: Section 720, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700 and 717, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.15. Oversight of Reinsurance Transactions.

(a) It is a condition to the issuance of a Certificate of Authority that the policyholder surplus of a licensed insurer shall at the time of admission and at all times subsequent be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, as determined by applying the following factors, among others:

1. The size of the insurer, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

2. The extent to which the insurer's business is diversified among the several lines of insurance.

3. The number and size of risks insured in each line of business.

4. The extent of the geographical dispersion of the insurer's insured risks.

5. The nature and extent of the insurer's reinsurance program.

6. The quality, diversification, and liquidity of the insurer's investment portfolio.

7. The recent past and projected future trend in the size of the insurer's investment portfolio.

8. The recent past and projected future trend in the size of the insurer's surplus, and the policyholder surplus maintained by other comparable insurers.

9. The adequacy of the insurer's reserves.

10. The quality and liquidity of investments in subsidiaries made under Code Section 1215.1. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of the policyholder's surplus whenever, in his judgment, the investment so warrants.

11. The quality of the company's earnings and the extent to which the reported earnings include extraordinary accounting items.

(b) Except for cessions to affiliates, the failure of a domestic insurer or volume insurer to retain at least 10% of direct premium written per line of business may be grounds for a finding that the insurer's reinsurance arrangements are materially deficient for purposes of Code Section 717(d). The Commissioner may consent to a lesser percentage of retained risk upon demonstrated business necessity. If the consent permitted by this subdivision is not obtained during the review of a filing made pursuant to Code Section 1215.5(b)(3) or subdivisions (e) or (g) of this section, an application for such consent may be made in the manner provided in Section 2303.22(f) of this article.

(c) As used in this section:

1. "One party" includes a pool of affiliated insurers, or two or more insurers within the same group of affiliated insurers.

2. "Assumption" means assuming risk by indemnity reinsurance.

3. "Sale" or "purchase" includes the transaction commonly referred to as "assumption reinsurance."

(d) As used in Code Section 1011(c), the term "substantially its entire property or business" means an amount of business such that the sale, cession, assumption or purchase thereof has the potential to render a company insolvent or create a hazard to its policyholders or creditors. A sale, cession, assumption or purchase that equals or exceeds either 75% of an insurer's total premium or 75% of its total liabilities, calculated before the subject transaction, shall constitute "substantially its entire property or business" for purposes of Code Section 1011(c). This subdivision shall not be construed as limiting the type of transactions within the scope of Code Section 1011(c).

(e) A licensed insurer that enters a transaction, under one or more agreements with one party, that is within the scope of subdivision (d) of this section without obtaining the prior written consent of the Commissioner as provided in this article is subject to a proceeding initiated pursuant to Code Section 1011. An application for the Commissioner's consent to such a transaction may be submitted as provided in Section 2303.22(g) of this article, and shall satisfy any filing requirement of Code Section 1215.5(b)(3) for the transaction.

Where the transaction is an affiliate transaction by a licensed insurer that is a member of an insurance holding company system and the insurer is exempt from registration pursuant to Code Section 1215.4(a), the application shall be in the form of a notice of the transaction submitted by the insurer to the Department as provided in Section 23022.22(g) of this article. The notice shall include: (1) the names and relationships of the parties to the transaction, (2) the identity of the domiciliary regulator responsible for review of the transaction pursuant to the applicable insurer holding company system act, (3) an estimate of total liabilities ceded under the agreement, and (4) a copy of the reinsurance agreement. Unless the Commissioner objects within 90 days of receipt of the notice, the Commissioner shall be deemed to have consented to the transaction.

(f) The Commissioner's consent to a cession of 100% of direct written premium on prospective business to an inter–company pool shall be conditioned upon (1) the agreement providing a retrocession to the ceding insurer of an amount not less than 10% of its direct written premium, and (2) the ceding insurer either maintaining surplus at a level sufficient to cover its direct writings, or including within the reinsurance agreement provisions that protect the ceding insurer in a manner satisfactory to the Commissioner.

(g) Unless a reinsurance agreement is filed with the Department pursuant to Code Sections 1011.5 or 1215.5(b)(3), or is an affiliate transaction by a licensed insurer that is a member of an insurance holding company system and the insurer is exempt from registration pursuant to Code Section 1215.4(a), a licensed insurer which intends to sell, cede, assume or purchase an amount of business that equals or exceeds either 50% of its total premium or 50% of its total liabilities under one or more agreements with one party, shall submit the proposed transaction to the Commissioner for his examination and a determination that the transaction is not objectionable for purposes of Code Section 717(d). The 50% calculation shall be made before the subject transaction. The transaction shall be submitted for examination as provided in Section 2303.22(h) of this article and shall be deemed not objectionable if the Commissioner has not objected within 90 days of its receipt by the Department.

(h) For purposes of the calculations required by subdivision (d) and subdivision (g) of this section:

1. "Total premium" and "total liabilities" include both direct and assumed business.

2. "Total liabilities" shall mean:

A. In the case of property and casualty business, the aggregate of the following items:

(i) Reserves for losses reported and outstanding;

(ii) Reserves for losses incurred but not reported;

(iii) Reserves for allocated loss expenses; and

(iv) Unearned premiums.

B. In the case of life and health business, the aggregate of the following items:

(i) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

(ii) Aggregate reserves for accident and health policies;

(iii) Deposit funds and other liabilities without life or disability contingencies; and

(iv) Liabilities for policy and contract claims.

3. "Liabilities" shall include modified coinsurance reserves for reinsurance assumed and shall exclude modified coinsurance reserves for reinsurance ceded.

(i) Where security for a cession is not provided because the reinsurer is a licensed insurer or an accredited reinsurer, the Commissioner may condition consent or non–objection to a transaction filed with the Department by a domestic or volume insurer pursuant to subdivision (e) or (g) of this section upon including within the reinsurance agreement provisions that protect the ceding insurer in a manner satisfactory to the Commissioner.

(j) If the ceding insurer is either a domestic insurer or a volume insurer, and the reinsurance agreement provides for the transmission of payments between the parties through an intermediary, then the following provisions shall apply:

1. Consent, approval or non–objection to the transmission of payments through the intermediary in a transaction filed with the Department pursuant to subdivision (e) or (g) of this section may be conditioned upon the intermediary providing the following documents, authenticated as required by Section 2303.17(c) of this article:

A. A copy of the intermediary's most recent financial statement provided to its client insurer;

B. A copy of the intermediary's most recent independent audit report, if any;

C. If the intermediary is not independently audited, an un-audited balance sheet, income statement, and statement of cash flow, each with an "as of" date of not more than 90 days prior to the date of filing of the reinsurance agreement under review by the Department;

D. A statement of funds the intermediary holds in fiduciary accounts; and

E. A description of any professional liability or fidelity insurance policies or bonds naming the intermediary as an insured or principal.

2. A satisfactory examination report of the intermediary issued by the Department with an "as of" date of not more than 3 years prior to the date of the filing of the reinsurance agreement under review by the Department may be submitted by the intermediary in lieu of the items listed in paragraph (1) above.

3. At his discretion, the Commissioner may initiate an examination of the intermediary and condition his consent, approval or non-objection to the transmission of payments through the intermediary upon the subsequent receipt of a satisfactory examination report. In determining whether an examination should be initiated, the Commissioner shall consider the projected aggregate amount of payments to be transmitted quarterly through the intermediary, the relative financial strength of the parties to the agreement, the availability and adequacy of any fidelity bonds or insurance, and the length of time since the last examination of the intermediary, if any. Transmission of payments through the intermediary shall be deemed non-objectionable to the Commissioner for the subject agreement, if he has not objected to the payment arrangement on the grounds of an unsatisfactory examination report within 180 days after issuing the conditional consent, approval or non-objection.

(k) The Department may coordinate the examination of a transaction with other interested state regulatory authorities. In the case of an affiliate transaction filed with the Department pursuant to subdivision (e) of this section by a licensed insurer that is a member of an insurance holding company system and is exempt from registration pursuant to Code Section 1215.4(a), the Department shall coordinate its examination of the transaction with the domestic state regulatory authority that is principally responsible for the licensed insurer's holding company system transactions.

(*l*) Upon denial of an application for consent filed pursuant to subdivision (e) of this section, or disapproval or objection to a transaction filed pursuant to Code Section 1215.5(b)(3) or subdivision (g) of this section, the Department shall issue a finding in the form of a written explanation setting forth the reasons for the determination. The determination may be appealed to the Chief of the Financial Surveillance Branch or to the successor position after a reorganization of the Department, in a manner consistent with making a request for a permitted accounting practice.

(m) If, subsequent to the Commissioner's consent, approval or non-objection to an agreement, the parties desire to amend the agreement, notice of the proposed amendment shall be filed with the Commissioner not less than 30 days prior to its execution for a determination of whether a new application or filing will be required. Notice shall be filed in the manner prescribed in Section 2303.22(k) of this article. A copy of the notice shall also be provided to the Department's financial analyst and attorney who had been assigned review of the initial application or filing. The notice shall include a copy of the amendment and an explanation of the reason therefor, along with a copy of the Commissioner's prior written consent or non-objection, if any. "Consent" includes transactions where consent is deemed pursuant to subdivision (e) of this section. "Non-objection" includes transactions deemed not objectionable pursuant to subdivision (g) of this section. The amendment shall not require a new application or filing if the Commissioner has not advised of the need for such within 30 days of receipt of the notice; however, the failure to timely object shall not be construed to limit the power of the Commissioner to object to the amendment upon a subsequent renewal or amendment of the amended agreement.

(n) The reporting requirements of subdivision (m) of this section shall not apply to a special acceptance. As used in this subdivision, "special acceptance" means the extension of a reinsurance contract to embrace a specific risk not automatically included within its terms, for example, a different class of business, an inordinate size of obligation, or an excluded risk, where, once accepted, all other contract terms apply.

(o) Any consent granted by the Commissioner is conditioned upon the truth and veracity of the documents and information submitted by or on behalf of the licensed insurer making the application or filing. If the Department determines that the documents or information submitted were materially false or misleading, or that material information was not disclosed, the consent granted shall be void ab initio. If the Department determines that a licensed insurer has violated the terms of the consent granted in any manner, the consent granted may be terminated immediately at the discretion of the Commissioner. As used in this subdivision, "consent granted" includes an approval, the issuance of a notice of non-objection, and the failure to timely respond to a notice or filing made pursuant to subdivisions (e), (g) or (m) of this section. Willfully providing false information to the Department for any purpose shall constitute a material deficiency under Code Section 717(e) and (h) and is grounds for revocation of a Certificate of Authority.

(p) This article shall not be construed as limiting the type of reinsurance arrangements that may be determined materially deficient for purposes of Code Section 717(d).

(q) When a licensed insurer is sold as a corporate shell, or when a sale of the insurer or other circumstance results in a significant change in the insurer's operations so that all or a majority of the documents previously submitted to the Department by the insurer concerning its operations are no longer valid:

1. The insurer shall, within 60 days after a sale or other significant change in its' operations, submit for examination by the Department all documents the Department deems necessary to determine compliance with Code Section 700(c); for good cause shown, the time to submit required documents may be extended;

2. A filing for a determination of compliance with Code Section 700(c) may be made in the manner set forth in Section 2303.22(i) of this article;

3. The insurer may continue its operations while the examination is pending;

4. With respect to a licensed insurer not seeking an amendment to its Certificate of Authority or other approval from the Department, the burden of establishing any material deficiency under Code Section 717 shall be on the Department; and

5. Notwithstanding the provisions of this subdivision, a licensed insurer shall not transact insurance, as that term is defined in Code Section 35, without first obtaining the approvals that may be required from the Department, such as prior approvals for rates or policy forms.

(r) When the Department requests a formal commitment from a licensed insurer to undertake a future act, the commitment made on behalf of the insurer shall be in the form of a certified copy of a board resolution or, at the discretion of the Department, a writing signed by (1) the insurer's chairman, president or any vice president and (2) the insurer's corporate secretary, any assistant secretary, chief financial officer or any assistant treasurer. The Department may require that signatures be notarized.

(s) The verified report of examination required by Code Section 734.1 to be issued after a regularly scheduled examination of all the affairs of a licensee shall not routinely be issued in conjunction with the limited examination of a licensee's reinsurance arrangements that is required or permitted by this article. Nor shall a verified report of examination routinely be issued for examinations that are limited in scope and undertaken in the routine oversight of a licensee's financial affairs. Notwithstanding the foregoing, a formal report of examination shall be issued upon the written request of the examined licensed insurer. The written request shall include an acknowledgement that further examination may be nec-

essary in order to prepare the formal report of examination specified in Code Section 734.1.

NOTE: Authority cited: Sections 720, 730, 736, 923, 1011.5, 1215.8, 1781.12 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 923, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f), 1781.10 and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.16. List of Volume Insurers.

(a) The definition of "volume insurer" in Section 2303.2(w) of this article uses the same threshold test as that used for a "commercially domiciled" insurer in Code Section 1215.13(a) of the Holding Company Act. By definition, all commercially domiciled insurers are volume insurers under this article. However, not all volume insurers are commercially domiciled insurers, in that a licensed insurer may meet the threshold test for volume insurer and not be a member of an insurance holding company system.

(b) On or before April 15 of each year, the Department shall publish on the Department's public website a list of foreign insurers that have attained the status of volume insurer for the year, and a list of foreign insurers that have attained the status of commercially domiciled insurer for the year.

NOTE: Authority cited: Section 720, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700 and 717, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.17. Examination of Reinsurance Intermediaries.

(a) The Commissioner may examine the business and affairs of a reinsurance intermediary whenever he deems necessary, or upon application as provided in this article. The examination shall include a determination of the intermediary's compliance with applicable provisions of the California Insurance Code and its ability to fulfill its obligations.

(b) An application for an examination by the Commissioner of a licensed reinsurance intermediary may be made by a licensed insurer on behalf of the intermediary, or by the intermediary. The application shall include:

1. A copy of each financial statement provided by the intermediary to its client insurers within the three years prior to the filing of the application;

2. A copy of each audit report with an "as of" date within the three years prior to the filing of the application, along with responses to the report findings, if any;

3. If the intermediary is not independently audited, an un–audited balance sheet, income statement, and statement of cash flow, each with an "as of" date of not more than 120 days;

4. A statement of funds held in fiduciary accounts;

5. A description of any professional liability or fidelity insurance policies or bonds naming the intermediary as an insured or principal;

6. If the application is requested by an insurer on behalf of an intermediary, a written consent by the intermediary to the examination; and

7. Additional documents and records as may be requested by the Commissioner.

(c) Each financial statement submitted to the Department by or on behalf of an intermediary shall be certified by an officer of the intermediary as being a true copy of the original, and shall contain a statement signed by the intermediary's chief financial officer under penalty of perjury attesting to the veracity of the financial statement.

(d) Following completion of an examination, the Department shall provide the intermediary with a copy of the examination report, together with a notice that the intermediary has 15 days to make a written submission or rebuttal with respect to any matters contained within the examination report. Within 15 days after expiration of the time to respond, the Commissioner shall fully consider the examination report and any responsive submissions by the intermediary and either adopt the examination report as prepared by the examiner or with modifications or corrections, or reject the examination report and require re–opening of the examination for purposes of obtaining additional information.

(e) In conducting the examination, the Commissioner shall observe those guidelines and procedures set forth in the Examiner's Handbook adopted by the NAIC as may be relevant to the examination of an intermediary, and may employ other guidelines or procedures which he deems appropriate. All documents disclosed in connection with the examination may be used by the Commissioner and shall be given confidential treatment by the Commissioner to the same extent as provided in Code Section 735.5 for documents disclosed in connection with the examination of insurers.

(f) An examination of an intermediary shall be at the expense of the intermediary, unless the examination is undertaken at the request of an insurer. The Commissioner shall not commence an examination requested by an insurer until receipt of a written commitment from the insurer, satisfactory to the Commissioner, that the insurer shall promptly pay all costs of the examination.

(g) Requests for an examination of a reinsurance intermediary shall be made following the procedures set forth in Section 2303.22(j) of this article.

(h) A licensed intermediary shall annually file with the Department a copy of the financial statement required by Code Sections 1781.6(c) or 1781.9(b), authenticated as required by subdivision (c) of this section.

NOTE: Authority cited: Section 1781.12, Insurance Code. Reference: Section 1781.10, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.18. Reporting of Regulatory Action.

An insurer that is either licensed or accredited in this state shall provide written notice to the Department within five (5) days of receipt of notice in any form or manner that it is the subject of a regulatory order or regulatory oversight by any state in which it is licensed concerning a hazardous financial condition. Where the regulatory action is confidential, disclosure to the Department is required only if permitted by the regulator issuing the order or initiating the oversight.

NOTE: Authority cited: Sections 720, 730, 922.8, 1011 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 717, 730, 733, 922.4, 923, 925, 925.2, 925.4, 1011, 1215.5(f) and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.19. Denial of Statement Credit and Non–Admission of Assets.

(a) Credit on financial statements for reinsurance ceded shall be denied if the applicable requirements of Sections 2303.3 through 2303.13 of this article have not been met, by non–admission of recoverables on paid losses, disallowance of recoverables on unpaid losses, or a requirement to use deposit accounting for the cession.

(b) Reinsurance recoverables that are due more than 90 days from a reinsurer to a domestic insurer on paid losses or paid loss adjustment expenses may, in the Commissioner's discretion, be required to be reported as non–admitted assets. A domestic insurer may follow the NAIC Accounting Guidance when reporting reinsurance recoverables due more than 90 days on its financial statements, unless the Commissioner expressly requires the financial statements to reflect the subject recoverables as non–admitted assets.

(c) Upon a determination that credit for reinsurance ceded shall not be permitted or an asset is deemed non–admitted, the Department shall issue a finding in the form of a written explanation to the ceding insurer setting forth the reasons for the determination. The determination may be appealed to the Chief of the Financial Surveillance Branch or to the successor position after a reorganization of the Department, in a manner consistent with making a request for a permitted accounting practice.

(d) Denial of credits on financial statements for reinsurance ceded pursuant to subdivisions (a) and (b) of this section shall not be construed to

be the only adjustments for reinsurance contemplated under the California Insurance Code. To the extent that the NAIC Accounting Guidance prescribes additional reductions in credits for reinsurance or additional liability provisions for reinsurance, the NAIC Accounting Guidance shall be followed.

(e) If a volume insurer is denied statement credit pursuant to this section or elects to forego a claim for statement credit in California to avoid compliance with a requirement of this article, the volume insurer shall report any variance between the credit claimed in California and the credit claimed in its state of domicile. The variance shall be reported on a form specified by the Department in the annual statement instructions. The Department may consider the variance in all evaluations of the financial strength of the volume insurer, including, but not limited to, whether to restrict the insurer's writing of new business in California.

NOTE: Authority cited: Sections 720, 736, 922.8, 923 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 717, 730, 733, 900, 922.2, 922.3, 922.4, 922.5, 922.6, 923, 1011, 1215.5(f) and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.20. Commissioner's Discretion.

The Commissioner may exercise discretion in requiring strict compliance with the requirements of this article where the Commissioner determines that (1) the variance is reasonable and justifiable in relation to the insurer's overall financial condition, (2) the true financial condition of the insurer may be elicited from analysis of the financial statements and other public documents as may be filed, and (3) compliance would cause undue hardship to the insurer.

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 923, 1011.5, 1215.8 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 900, 922.1, 922.2, 922.4, 922.5, 922.6, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f) and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.21. Insurer Default for Failure to Comply.

For purposes of Code Section 701, "governmental control" includes the requirements placed upon licensed insurers by this article.

NOTE: Authority cited: Section 720, Insurance Code. Reference: Section 701, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.22. Required Deposits, Fees and Filing Offices.

(a) All costs and expenses incurred by the Department in connection with the review of an application, request or filing made under this article by or on behalf of an insurer or reinsurance intermediary in excess of any deposit paid shall be billed to the insurer or reinsurance intermediary making the application, request or filing. The Commissioner shall maintain a schedule of the deposits required under this article on the Department's website and, after 90 days notice provided on the website schedule, may revise the deposit amounts as necessary to substantially cover the expected costs of review.

(b) As used in Code Section 924, which assesses late fees for the failure to make timely filings, the term "statements or stipulations" shall include all filings required by this article and the filings made pursuant to Code Section 1011.5.

(c) The initial application and annual filings required by Section 2303.4 of this article for accredited reinsurers shall be submitted in duplicate, except that only one copy of the items listed in Section 2303.4(b)(5)(D) of this article is required, accompanied by a deposit of $1,500.00. The application shall consist of a cover letter transmitting the items specified in Section 2303.4

(d) The initial application and annual filings required by Section 2303.5 of this article for an approved U.S. trust, and the application for approval of trust amendments, shall be submitted in duplicate, except that with respect to financial documents provided to the Oversight State, duplicate copies are required only of the audit report, actuarial opinion and CPA report. The requesting reinsurer or group of affiliated insurers shall provide the Department with a $3,000 deposit in conjunction with the initial application for approval of a U.S. trust, a $500 deposit for review of an amendment to the form of an approved U.S. trust, and a $1,500 deposit with the annual filing. The application shall consist of a cover letter transmitting the items specified in Section 2303.5.

(e) A deposit of $500 shall accompany examination requests made pursuant to Section 2303.8(d) of this article for a determination that a letter of credit form meets the requirements of Section 2303.8(c). The application shall consist of a cover letter and a copy of the proposed letter of credit.

(f) An application for the consent required by Section 2303.15(b) of this article to retain less than 10% of direct premium written per line of business shall be submitted for examination in duplicate, accompanied by a deposit of $1,500. The application shall include a cover letter explaining the proposed reinsurance arrangements, including the business necessity for the exception.

(g) An application submitted pursuant to Section 2303.15(e) of this article concerning a reinsurance agreement subject to Code Section 1011(c) shall be submitted in duplicate, accompanied by the fee required for an application made under Code Section 1011.5. The form and instructions for applications not in the form of the notice permitted by Section 2303.15(e) may be obtained from the Corporate Affairs Bureau at the address provided in subdivision (k) of this section or from the Department's public website at www.insurance.ca.gov.

(h) An application for the determination required by Section 2303.15(g) of this article concerning specified reinsurance agreements shall be submitted for examination in duplicate, accompanied by a deposit of $1,500. The application shall include a cover letter explaining the proposed transaction, a copy of the reinsurance agreement and any other relevant documents, and pro–forma financial statements for the term of the agreement, or three years, whichever is less, with and without the reinsurance.

(i) A filing for the examination required by Section 2303.15(q) of this article for a determination of compliance with Code Section 700(c) shall include all supporting documents required for an initial application for a Certificate of Authority, shall be made in duplicate, and shall be accompanied by a deposit of $1,500. The application forms and instructions may be obtained from the Corporate Affairs Bureau at the address provided in subdivision (k) of this section or from the Department's public website at www.insurance.ca.gov.

(j) Applications made pursuant to Section 2303.17 of this article for the examination of a reinsurance intermediary shall be submitted in duplicate, accompanied by a deposit of $1,000.

(k) The applications, annual filings and requests made pursuant to subdivisions (c) through (j) of this section shall be submitted to:

CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL BRANCH, CORPORATE AFFAIRS BUREAU
45 FREMONT STREET, 24TH FLOOR
SAN FRANCISCO, CA 94105

All other filings or notices required or permitted by this article shall be accompanied by an explanation of the reason for the filing or notice and shall be submitted to:

CALIFORNIA DEPARTMENT OF INSURANCE
FINANCIAL ANALYSIS DIVISION
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 924, 1011.5, 1215.8, 1781.12 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 717, 730, 733, 736, 922.5, 923, 924, 1011.5, 1215.5(b)(3) and 1781.10, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.23. Severability.

If any provision of this article, or the application of a provision to any person or circumstance, shall be held invalid, the remainder of the article, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 923, 1011.5, 1215.8 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 900, 922.1, 922.2, 922.4, 922.5, 922.6, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f) and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.24. Effective Date.

(a) Section 2303 through Section 2303.25 of this article shall become effective on January 1, 2007, or the 30th day following the day those sections are filed with the Secretary of State, whichever is later (the "Effective Date").

(b) No licensee may claim reserve credit for a new or renewal reinsurance agreement executed on or after the Effective Date unless the agreement and any security provided therefor conform to the applicable requirements of this article.

(c) All reinsurance agreements and any security provided therefor that are executed prior to the Effective Date shall remain subject to the requirements of Bulletin 97–5 issued pursuant to Code Section 922.8. Bulletin 97–5 is incorporated herein by reference for that limited purpose.

(d) Licensees shall continue to conform to the requirements of the NAIC Accounting Guidance, to the extent that those requirements do not conflict with applicable requirements of the Code and Bulletin 97–5, or, after the Effective Date, with this article.

NOTE: Authority cited: Sections 720, 730, 736, 922.8, 923, 924, 1011.5, 1215.8, 1781.12 and 12921, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 700, 701, 717, 730, 733, 736, 900, 922.1, 922.2, 922.3, 922.4, 922.5, 922.6, 922.7, 922.8, 922.9, 923, 924, 925, 925.2, 925.4, 1011, 1011.5, 1215.5(b)(3), 1215.5(f), 1781.10 and 12921, Insurance Code.

HISTORY

1. New section filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

§ 2303.25. Approved Forms.

(a) The Certificate of Assuming Insurer Form AR–1 as published in this section is required under Section 2303.4 and 2303.5 of this article.

(b) The Designation of Agent for Service of Process and Consent to Jurisdiction Form AR–2 as published in this section is a form acceptable to the Commissioner under the requirements of Sections 2303.4 and 2303.5 of this article.

(c) The Letter of Credit for Reinsurance Form AR–3 as published in this section is a form acceptable to the commissioner for the purpose of securing ceded reinsurance under Section 2303.8 of this article.

(d) Following are Forms AR–1 through AR–3:

NOTE: Authority cited: Section 922.8, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal. 3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 922.4 and 922.5, Insurance Code.

HISTORY

1. New section and new Forms AR–1, AR–2 and AR–3 filed 10–24–2006; operative 11–23–2006 (Register 2006, No. 43).

FORM AR–1

CERTIFICATE OF ASSUMING INSURER

The undersigned insurer, the Assuming Insurer under a reinsurance agreement with one or more insurers domiciled in California, hereby certifies that it:

1. Submits to the authority of the Insurance Commissioner of California ("Commissioner") to examine its books and records and agrees to bear the expense of any such examination.

2. Submits with this form a current list of insurers domiciled in California reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to Commissioner at least once per calendar quarter, unless the Commissioner approves another reporting interval for additions to or deletions from the list.

Assuming Insurer: _____

NAIC # _____

By (Chairman, President or any Vice President): _____

Title _____

Date: _____

By (Corporate Secretary, any Assistant Secretary, Chief Financial Officer or any Assistant Treasurer): _____

Title _____

Date: _____

State/County:

On _____ before me, _____, personally appeared _____ and _____, known to me (or proved to me on the basis of satisfactory evidence) to be the persons whose names are subscribed to the within instrument and acknowledged to me that they executed the same in their authorized capacity, and that by their signatures on the instrument the Assuming Insurer, upon behalf of which the persons acted, executed the instrument.

Witness my hand and official seal:

Signature _____ Notary Public

Form AR–1 (09/04)

DESIGNATION OF AGENT FOR SERVICE OF PROCESS AND CONSENT TO JURISDICTION

The undersigned, _____, a corporation organized under the laws of _____, hereby appoints and designates _____, having his/her place of business at _____ in the City of _____, California, as its agent for service of process, upon whom may be served any notice, summons or process in any action, suit, arbitration or proceeding instituted by or on behalf of an insurer domiciled in California or by the California Insurance Commissioner ("Commissioner"). If at any time the undersigned is without an agent for service of process, or service cannot be made upon the appointed agent, service may be made upon the Commissioner, and such service shall have the same force and effect as if made upon the undersigned. This appointment and designation shall terminate, without notice to the appointee, upon filing with the Commissioner a designation form appointing another agent.

The undersigned hereby consents to the jurisdiction of any court of competent jurisdiction in California for the adjudication of any issues arising from a reinsurance agreement with an insurer domiciled in California, or arising from its status as an accredited reinsurer or a reinsurer with an approved U.S. trust in California. The undersigned agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or appellate court in the event of an appeal. However, nothing in this paragraph constitutes a waiver of the right of the undersigned to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to arbitrate their disputes if such an obligation is created in an underlying agreement.

Name of Corporation _____

By _____(Officer)

Printed Name and Title of Officer:

ACKNOWLEDGMENT OF AGENT

I, _____, the appointee named above, hereby certify that I am a licensed attorney in California and the individual appointed herein as agent, and that I maintain an office at the address stated for me above. I agree to be reasonably available during normal business hours at such address for service on me for the appointing company of any notice, summons or process. I further agree that in the event the address of my office is changed during the existence of this appointment, I will promptly give notice thereof in writing to the appointing company and to the California Insurance Commissioner.

Signature _____

State of California Bar Number _____

Submit original to: California Department of Insurance, Corporate Affairs Bureau
45 Fremont Street, San Francisco, CA 94105

Form AR–2 (09/05)

LETTER OF CREDIT AS SECURITY FOR REINSURANCE CEDED

BANK:
ADDRESS:

Letter of Credit No. _____ Issue Date: _____

To Beneficiary: [Name of Insurer Beneficiary]

We have established this irrevocable, and unconditional Letter of Credit in your favor as beneficiary for drawings up to an aggregate of U.S. $_____, effective immediately. This Letter of Credit is issued, presentable and payable at our office at _____ and expires with our close of business on _____. Except when the amount is increased, this Letter of Credit cannot be modified or revoked without your written consent.

We will promptly honor your sight draft(s) drawn on us, indicating our Credit Number _____, for all or any part of this Letter of Credit, upon presentation at our office at the address given above, or such other office as we may advise, on or before the expiration date hereof or any automatically extended date. Other than your sight draft, no other document need be presented.

This Letter of Credit shall automatically extend without amendment for a period of one year from the expiration date, or any future expiration date, unless at least sixty (60) days prior to any expiration date we notify you by registered or certified mail, return receipt requested, or by overnight delivery service, signature upon delivery required, that this Letter of Credit shall not be renewed.

Our obligation under this Letter of Credit is unconditional and is not dependent upon our ability to perfect a lien, or obtain a security interest or any other form of reimbursement.

The term "beneficiary" as used herein includes any successor by operation of law of the named beneficiary. If a court of law appoints a successor in interest to the named beneficiary, then the term "beneficiary" includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

This Letter of Credit is subject to and governed by the laws of the State of California (excluding the conflict of law provisions), and the Uniform Customs and Practice for Documentary Credits, International Chamber of Commerce, Publication No. 500, or any successor publication, except where that publication is in conflict with California law. Notwithstanding Article 17 of said publication, if this Letter of Credit expires during an interruption of your business or our business, caused by an Act of God, riot, civil commotion, insurrection, war, terrorism, or any other cause beyond control or by any strike or lockout, we hereby specifically agree to pay as provided herein if this Letter of Credit is drawn against within 60 days after the resumption of business.

BANK: _____

AUTHORIZED SIGNATURE: _____

AR–3 (09/05)

§ 2305. Documents Accompanying the Fraternal Orders Annual Statement, Blank Which Must Be Signed by an Actuary.

(a) Documents accompanying the filing of the Fraternal Orders Annul Statement Blank with the State of California Insurance Department shall include a statement of actuarial opinion:

(1) Statement of Actuarial Opinion. The statement of actuarial opinion prepared by the actuary in accordance with the Instructions to the Fraternal Orders Annual Statement Blank.

(b) The details of actuarial analysis will be given in the statement of actuarial opinion. If it is necessary for more than one actuary to prepare statements of actuarial opinion, then each actuary shall prepare a separate statement of actuarial opinion.

(c) In preparing the statement of actuarial opinion, each actuary shall take particular care in the preparation of the opinion paragraph, making specific reference to the items and the amounts listed for which the actuary is submitting an opinion. If, for any reason, the actuary cannot render an unqualified opinion regarding any of the points defined in the instructions to the blank with respect to the opinion paragraph, specific details must be given as to why an unqualified opinion is not given. For the 1975 annual statement blank, the Department will consider restrictions of determination of opinion because of insufficient information only in those situations where the financial operations of the company appear to justify further actuarial analysis, and in those situations will require a complete statement of actuarial opinion on a delayed basis.

(d) After 1975 it is expected that the actuary will have sufficient time to prepare his statement of actuarial opinion so that each such statement of opinion will only on rare occasions be incomplete because of insufficient information.

NOTE: Authority cited: Section 12923(b), Insurance Code.

HISTORY

1. New section filed 12–5–75; effective thirtieth day thereafter (Register 75, No. 49).

§ 2306. Documents Accompanying the Life and Accident and Health Annual Statement Blank Which Must Be Signed by an Actuary.

(a) Documents accompanying the filing of the Life and Accident and Health Annual Statement Blank with the State of California Insurance Department shall include a statement of actuarial opinion:

(1) Statement of Actuarial Opinion. The statement of actuarial opinion prepared by the actuary in accordance with the Instructions to the Life and Accident and Health Annual Statement Blank.

(b) The details of actuarial analysis will be given in the statement of actuarial opinion. If it is necessary for more than one actuary to prepare a statement of actuarial opinion, each actuary shall prepare a separate statement of actuarial opinion.

(c) In preparing the statement of actuarial opinion, each actuary shall take particular care in the preparation of the opinion paragraph making specific reference to the items and the amounts listed for which the actuary is submitting an opinion. If, for any reason, the actuary cannot render an unqualified opinion regarding any of the points defined in the instructions to the blank with respect to the opinion paragraph, specific details must be given as to why an unqualified opinion is not given. For the 1975 Annual Statement Blank, the Department will consider restrictions of determination of opinion because of insufficient information only in those situations where the financial operations of the company appear to justify further actuarial analysis, and in those situations will require a complete statement of actuarial opinion on a delayed basis.

(d) After 1975 it is expected that the actuary will have sufficient time to prepare the statement of actuarial opinion so that such statement of opinion will only on rare occasions be incomplete because of insufficient information.

NOTE: Authority cited: Section 12923(b), Insurance Code.

HISTORY

1. New section filed 12–5–75; effective thirtieth day thereafter (Register 75, No. 49).

§ 2307. California Earthquake Zoning and Probable Maximum Loss Evaluation Program.

All insurers transacting property insurance in this State must record earthquake liabilities written in this State and develop statistics in accordance with the instructions contained in the Insurance Department, California Earthquake Liability Report Form.

Insurers specializing in the writing of unique or unusual risks may report on forms and plans that are submitted to the Insurance Department and found to be compatible with the uniform form. Exceptions will be granted only where compatibility is clearly demonstrated by the insurer.

(a) Insurers must provide their reinsurers zone, construction, PML and deductible information on the same basis and format as they submit to the Insurance Department for liabilities ceded under each reinsurance treaty other than catastrophe treaties. Reinsurers shall combine this information with their own facultative recordings for a total aggregate probable maximum loss estimate on their writings.

(b) Insurers writing risks under excess of loss, loss limit, aggregate, stop loss or similar covers must report the following information:

1. Zone designation
2. Company aggregate limit
3. Net probable Maximum Loss Insurers are expected to develop and maintain information on methodology of determining Net Probable Maximum Loss for review by the Department's examiners.

(c) Reports shall be filed with the Commissioner as an Addendum to the insurer's Annual Statement as of December 31st of each calendar year and shall be due June 30th of the following year. The first Earthquake Liability Report shall be due June 30, 1980, for the year ending December 31, 1979, and shall cover only policies written and effective on or after January 1, 1979.

NOTE: Authority cited: Sections 923 and 923.5, Insurance Code.

HISTORY

1. New section filed 8–15–78; effective thirtieth day thereafter (Register 78, No. 33).
2. Technical amendment to original filing of section filed 8–17–78 (Register 78, No. 33).

Article 3.5. Minimum Reserve Standards for Valuation Of Disability Insurance Contracts

§ 2310. General Rule.

(a) Applicability

These standards apply to all individual and group disability insurance except credit insurance and disability waiver of premium, disability income, and accidental death benefit riders that are supplementary to ordinary life insurance policies or contracts.

(b) Reserve Adequacy

With respect to any block of contracts, or with respect to an insurer's disability business as a whole, a prospective gross premium valuation is a valuable test of reserve adequacy as of a given valuation date. Such a gross premiums valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

Such a gross premium valuation shall be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's disability business as a whole. In the event inadequacy is found to exist, immediate recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

Whenever minimum reserves, as defined in this article, exceed reserve requirements as determined by a prospective gross premium valuation,

such minimum reserves remain the minimum requirement under this article.

When an insurer determines that adequacy of its disability insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

Adequacy of an insurer's disability insurance reserves shall be determined on the basis of the following three categories: claim reserves, premium reserves and contract reserves. Adequate reserves for each of the three categories shall be separately determined.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New article 3.5 and section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).

§ 2311. Definitions.

For purposes of this article, the following definitions apply:

(a) "Annual Claim Cost" is the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12, while the gross premium for this benefit might be $18. The additional $6 would cover expenses and profit or contingencies.

(b) "Claims Accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(c) "Claim Reported": When an insurer has been informed that a claim has been incurred, if the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

(d) "Claims Unaccrued" are the portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

(e) "Claims Unreported": When an insurer has not been informed, on or before the valuation date, concerning a claim that has been incurred on or prior to the valuation date, the claim is considered as an unreported claim for annual statement purposes.

(f) "Date of Disablement" is the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(g) "Elimination Period" is a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(h) "Gross Premium" is the amount of premium charged by the insurer. It includes the net premium (based on claim–cost) for the risk, together with any loading for expenses, profit or contingencies.

(i) "Group Insurance" includes blanket insurance and franchise insurance and any other forms of group insurance.

(j) "Level Premium" is a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time.

Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit por–

[The next page is 601.]

tion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(k) "Long–Term Care Insurance" is as defined in Insurance Code Section 10231.2.

(*l*) "Modal Premium" is the premium paid on a contract based on a premium term which could be annual, semi–annual, quarterly, monthly, or weekly. Thus if the annual premium is $100 and if, instead, monthly premiums of $9 are paid then the modal premium is $9.

(m) "Negative Reserve": Normally the terminal reserve is a positive value. If, however, the values of the benefits are decreasing with advancing age or duration it could be a negative value, called a negative reserve.

(n) "Preliminary Term Reserve Method" is a method of reserve valuation under which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium (or stream of changing valuation premiums) becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(o) "Present Value of Amounts Not Yet Due on Claims" is the reserve for "claims unaccrued" (as defined in subsection (d)), which may be discounted at interest.

(p) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued.

An insurer under its contracts promises benefits which result in:

(1) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which shall be provided for by establishing claim reserves; or

(2) Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims shall be provided for by the establishment of contract reserves and unearned premium reserves.

(q) "Terminal Reserve" is the reserve at the end of a contract year, and is defined as the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(r) "Unearned Premium Reserve" values that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of $120 was paid on November 1, $20 would be earned as of December 31 and the remaining $100 would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(s) "Valuation Net Modal Premium" is the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).

§ 2312. Claim Reserves.

(a) General Rules

(1) Claim reserves are required for all incurred but unpaid claims (these include all claims accrued and unaccrued, reported and unreported) on all disability insurance policies as defined in § 2310(a).

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims.

(3) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the financial statement as required by Insurance Code §§ 900 and 923 including consideration of any residual unpaid liability.

(b) Minimum Standards for Claim Reserves

(1) Disability Income

(A) Interest. The maximum interest rate for claim reserves is specified in § 2315.

(B) Morbidity. Minimum standards with respect to morbidity are those specified in § 2315; except that, at the option of the insurer:

1. For individual disability income claims incurred on or after January 1, 2005, assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the insurer's experience, if such experience is credible, or upon other assumptions designed to place a sound value on the liabilities.

2. For group disability income claims incurred on or after January 1, 2005:

(i) Assumptions regarding claim termination rates for the period less than two (2) years from the date of disablement may be based on the insurer's experience, if the experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(ii) Assumptions regarding claim termination rates for the period of two (2) or more years but less than five (5) years from the date of disablement may, with the approval of the Commissioner, be based upon the insurer's experience for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

I. An analysis of the credibility of the experience;

II. A description of how all of the insurer's experience is proposed to be used in setting reserves;

III. A description and qualification of the margins to be included;

IV. A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual statement;

V. A copy of the approval of the proposed plan of modification by the Commissioner of the state of domicile; and

VI. Any other information requested by the Commissioner.

3. For disability income claims incurred prior to January 1, 2005 each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(ii) The standards as defined in Items 1. and 2., applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in Items 1. and 2., all future valuations must be on that basis.

(C) Duration of Disablement. For contracts with an elimination period, the duration of disablement shall be measured as dating from the time that benefits would have begun to accrue had there been no elimination period.

(2) All Other Benefits

(A) Interest. The maximum interest rate for claim reserves is specified in § 2315.

(B) Morbidity or other Contingency. The reserve shall be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) Claim Reserve Methods Generally

Any generally accepted or reasonable actuarial method or combination of methods may be used to estimate all claim liabilities. The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. Approximations based on groupings and averages may also be employed. Adequacy of the claim reserves, however, shall be determined in the aggregate.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).
2. Amendment filed 12–13–2005; operative 12–13–2005 pursuant to Government Code section 11343.4 (Register 2005, No. 50).

§ 2312.3. Premium Reserves.

(a) General Rules

(1) Unearned premium reserves are required for all contracts with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(2) If premiums due and unpaid are carried as an asset, such premiums shall be treated as premiums in force, subject to unearned premium reserve determination. The value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums shall be carried as an offsetting liability.

(3) The gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation may be discounted, at rates not exceeding those in § 2315(b), to the valuation date and shall be held either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(b) Minimum Standards for Unearned Premium Reserves

(1) The minimum unearned premium reserve with respect to any contract shall be the pro rata unearned modal premium that applies to the premium period beyond the valuation date, with such premium determined on the basis of:

(A) The valuation net modal premium on the contract reserve basis applying to the contract; or

(B) The gross modal premium for the contract if no contract reserve applies.

(2) In no event shall the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(c) Premium Reserve Methods Generally

The insurer may employ suitable approximations and estimates, including, but not limited to groupings, averages and aggregate estimation, in computing premium reserves. Such approximations or estimates shall be tested periodically to determine their continuing adequacy and reliability.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).

§ 2312.5. Contract Reserves.

(a) General Rules

(1) Contract reserves are required, unless otherwise specified in paragraph (a)(2) for:

(A) All individual and group contracts with which level premiums are used; or

(B) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. This evaluation may be applied on a rating block basis if the total premiums for the block were developed to support the total risk assumed and expected expenses for the block each year, and a qualified actuary certifies the premium development. The actuary should state in the certification that premiums for the rating block were developed such that each year's premium was intended to cover that year's costs without any prefunding. If the premium is also intended to recover costs for any prior years, the actuary should also disclose the reasons for and magnitude of such recovery. The values specified in this paragraph shall be calculated based on subsection §2312.5(b).

(2) Contracts not requiring a contract reserve are:

(A) Contracts which cannot be continued after one year from issue; or

(B) Contracts already in force on the effective date of this article for which no contract reserve is required under Section 997 of the Insurance Code.

(3) The contract reserve shall be in addition to claim reserves and premium reserves.

(4) The methods and procedures for the calculation of contract reserves shall be consistent with those for claim reserves for any contract, or else appropriate adjustment shall be made when necessary to assure provision for the aggregate liability. The definition of the date of incurral must be the same in both determinations.

(5) The total contract reserve established shall incorporate provisions for moderately adverse deviations.

(b) Minimum Standards for Contract Reserves

(1) Basis.

(A) Morbidity or other Contingency. Minimum standards with respect to morbidity are those set forth in §2315. Valuation net premiums used under each contract shall have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. Contracts for which tabular morbidity standards are not specified in §2315 shall be valued using tables established for reserve purposes by a qualified actuary with the approval of the Commissioner. The morbidity tables shall contain a pattern of incurred claims cost that reflects the underlying morbidity and shall not be constructed for the primary purpose of minimizing reserves.

1. In determining the morbidity assumptions, the actuary shall use assumptions that represent the best estimate of anticipated future experience, but shall not incorporate any expectation of future morbidity improvement. Morbidity improvement is a change, in the combined effect of claim frequency and the present value of future expected claim payments given that a claim has occurred, from the current morbidity tables or experience that will result in a reduction to reserves. It is not the intent of this provision to restrict the ability of the actuary to reflect the morbidity impact for a specific known event that has occurred and that is able to be evaluated and quantified.

2. Business in force as of the effective date of §2312.5(b)(1)(C)2. may be permitted to retain the original reserve basis which may not meet the provisions of Item 1. above, subject to the acceptability to the Commissioner.

(B) Interest. The maximum interest rate is specified in §2315.

(C) Termination Rates. Termination rates used to compute reserves shall be on the basis of a mortality table as specified in § 2315 except as noted in the following paragraphs:

1. Under contracts for which premiums rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard or for return of premium or other deferred cash benefits, total termination rates may be used at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) Eighty percent of the total termination rate used in the calculation of the gross premiums, or

(ii) Eight percent.

2. For long–term care individual policies or group certificates issued on or after January 1, 2005, the contract reserve shall be established on the basis of:

(i) Mortality (as specified in §2315); and

(ii) Terminations other than mortality, where the terminations are not to exceed:

I. For policy year one, the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and six percent (6%);

II. For policy years two (2) through four (4), the lesser of eighty percent (80%) of the voluntary lapse rate used in the calculation of gross premiums and four percent (4%); and

III. For policy years five (5) and later, the lesser of one hundred percent (100%) of the voluntary lapse rate used in the calculation of gross premiums and two percent (2%), except for group insurance as defined in Section 10231.6 of the Insurance Code, where the 2% shall be three percent (3%)

3. Where a morbidity standard specified in §2315 is on an aggregate basis, such morbidity standard may be adjusted to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and must be approved by the Commissioner.

(2) Reserve Method.

(A) For all disability insurance as defined in § 2310(a) except for contracts issued on or after January 1, 1995, which provide long–term care and return of premium or other deferred cash benefits, the minimum reserve shall be the reserve calculated on the two–year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(B) For long–term care insurance issued on or after January 1, 1995, the minimum reserve shall be the reserve calculated on the one–year full preliminary term method.

(C) For return of premium or other deferred cash benefits issued on or after January 1, 1995, the minimum reserve shall be the reserve calculated as follows:

1. On the one year preliminary term method if such benefits are provided at any time before the twentieth anniversary;

2. On the two year preliminary term method if such benefits are only provided on or after the twentieth anniversary.

(D) The preliminary term method may be applied only in relation to the date of issue of a contractual obligation. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions (e.g., projected inflation rates) or for other reasons, shall be applied immediately as of the effective date of adoption of the adjusted basis.

(3) Negative Reserves. Negative reserves on any benefit may be offset against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined shall not be less than zero.

(4) Nonforfeiture Benefits for Long–Term Care Insurance.

The contract reserve on a policy basis shall not be less than the net single premium for the nonforfeiture benefits at the appropriate policy duration, where the net single premium is computed according to the above specifications.

(c) Alternative Valuation Methods and Assumptions Generally

Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above, an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. Also subject to the preceding condition, an insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following: the net level premium method; the one–year full preliminary term method; prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses; the use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms; the computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and the use of a composite annual claim for all or any combination of the benefits included in the contracts valued.

(d) Tests For Adequacy and Reasonableness of Contract Reserves

Annually, an appropriate review shall be made of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves, giving consideration to future gross premiums. The insurer shall make appropriate increases to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate subject to the minimum standards in subsection (b).

If an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, insurance department regulations, or for other reasons, such that the future gross premiums reduced by expenses for administration, commissions and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfall in the aggregate.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).
2. Amendment filed 12–13–2005; operative 12–13–2005 pursuant to Government Code section 11343.4 (Register 2005, No. 50).

§ 2313. Reinsurance.

Increases to, or credits against, reserves carried, arising because of reinsurance assumed or reinsurance ceded, shall be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).

§ 2314. Reserves for Waiver of Premium.

(a) Because the disability valuation tables promulgated by the NAIC are based on exposures that include contracts on premium waiver as in–force contracts, contract reserves based on these tables are NOT reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB tables.

Accordingly, tabular reserves using any of these tables shall value reserves on the following basis:

(1) Claim reserves shall include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

(2) Premium reserves shall include contracts on premium waiver as in–force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

(3) Contract reserves shall include recognition of the waiver of premium benefit in addition to other contract benefits, valuing as a minimum the valuation net premium to be waived.

(b) If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis shall determine whether additional liability shall be recognized because of premiums waived during periods of disability or during claim continuation.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).

§ 2315. Specific Standards for Morbidity, Interest and Mortality.

(a) Morbidity

(1) Minimum morbidity standards for valuation of specified individual contract benefits:

(A) Disability Income Benefits Due to Accident or Sickness.

1. Contract Reserves

For contracts issued on or after January 1, 1965 and prior to January 1, 1995: use either the 1964 Commissioners Disability Table or the 1985 Tables described below.

For contracts issued on or after January 1, 1995: The 1985 Commissioners Individual Disability Tables A (85CIDA); or The 1985 Commissioners Individual Disability Tables B (85CIDB). 85 CIDA, also called the Basic Valuation Table, is found in Transactions of the Society of Actuaries, Volume XXXVII, pages 449–460. 85CIDB, also called the "83c

Table", is found in Proceedings of the NAIC, 1985, Volume 1, pages 494–540.

Each insurer shall elect, with respect to all individual contracts issued in any one statement year, either Tables A or Tables B as the minimum standard. The insurer may elect to use the other tables with respect to any subsequent statement year.

2. Claim Reserves

(i) For claims incurred on or after January 1, 2005:

The 1985 Commissioners Individual Disability Tables A (85CIDA) in 1985 Transactions of the Society of Actuaries, Volume XXXVII, pages 455–463, incorporated by reference herein, with claim termination rates multiplied by the following adjustment factors:

Duration	*Adjustment Factor*	*Adjusted Termination Rates**
Week 1	0.366	0.04831
2	0.366	0.04172
3	0.366	0.04063
4	0.366	0.04355
5	0.365	0.04088
6	0.365	0.04271
7	0.365	0.04380
8	0.365	0.04344
9	0.370	0.04292
10	0.370	0.04107
11	0.370	0.03848
12	0.370	0.03478
13	0.370	0.03034
Month 4	0.391	0.08758
5	0.371	0.07346
6	0.435	0.07531
7	0.500	0.07245
8	0.564	0.06655
9	0.613	0.05520
10	0.663	0.04705
11	0.712	0.04486
12	0.756	0.04309
13	0.800	0.04080
14	0.844	0.03882
15	0.888	0.03730
16	0.932	0.03448
17	0.976	0.03026
18	1.020	0.02856
19	1.049	0.02518
20	1.078	0.02264
21	1.107	0.02104
22	1.136	0.01932
23	1.165	0.01865
24	1.195	0.01792
Year 3	1.369	0.16839
4	1.204	0.10114
5	1.199	0.07434
6 and later	1.000	**

* The adjusted termination rates derived from the application of the adjustment factors to the DTS Valuation Table termination rates shown in exhibits 3a, 3b, 3c, 4, and 5 (1985 Transactions of the Society of Actuaries (TSA), Volume XXXVII, pp. 457–463, 465, incorporated by reference herein, are displayed. The adjustment factors for age, elimination period, class, sex, and cause displayed in exhibits 3a, 3b, 3c, and 4 should be applied to the adjusted termination rates shown in this table.

** Applicable DTS Valuation Table duration rate from exhibits 3c and 4 (1985 TSA Volume XXXVII, pp. 462–463), incorporated by reference herein.

The 85CIDA tables so adjusted for the computation of claim reserves shall be known as 85CIDC (The 1985 Commissioners Individual Disability Tables C, which is the 85CIDA tables in 1985 Transactions of the Society of Actuaries, Volume XXXVII, pp. 455–463, so adjusted, incorporated by reference herein.).

(ii) For claims incurred prior to January 1, 2005:

Each insurer may elect which of the following to use as the minimum standard for claims incurred prior to January 1, 2005:

(I) The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred, or

(II) The standard as defined in Item (i), applied to all open claims.

(III) Once an insurer elects to calculate reserves for all open claims on the standard defined in Item (i), all future valuations must be on that basis.

(B) Hospital Benefits, Surgical Benefits and Maternity Benefits (Scheduled benefits or fixed time period benefits only).

1. Contract Reserves

For contracts issued on or after January 1, 1955, and before January 1, 1982: The 1956 Intercompany Hospital–Surgical Tables.

For contracts issued on or after January 1, 1982: The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

2. Claim Reserves: No specific standard. See paragraph (E).

(C) Cancer Expense Benefits (Scheduled benefits or fixed time period benefits only).

1. Contract Reserves

For contracts issued on or after January 1, 1986: The 1985 NAIC Cancer Claim Cost Tables.

2. Claim Reserves: No specific standard. See paragraph (E).

(D) Accidental Death Benefits

1. Contract Reserves

For contracts issued on or after January 1, 1965: The 1959 Accidental Death Benefits Table.

2. Claim Reserves: Actual amount incurred.

(E) Other Individual Contract Benefits

1. Contract Reserves

For all other individual contract benefits, morbidity assumptions are to be determined as provided in this article.

2. Claim Reserves

For all benefits other than disability income, claim reserves are to be determined as provided in this article.

(2) Minimum morbidity standards for valuation of specified group contract benefits:

(A) Disability Income Benefits Due to Accident or Sickness.

1. Contract Reserves

For contracts issued prior to January 1, 1995: The same basis, if any, as that employed by the insurer as of January 1, 1995

For contracts issued on or after January 1, 1995: The 1987 Commissioners Group Disability Income Table (87CGDT; Transactions of the Society of Actuaries, Volume XXXIX, pages 393–458).

2. Claim Reserves

For claims incurred on or after January 1, 1995: The 1987 Commissioners Group Disability Income Table (87CGDT; Transactions of the Society of Actuaries, Volume XXXIX, pages 393–458).

For claims incurred prior to January 1, 1995: Use of the 87CGDT is optional.

(B) Other Group Contract Benefits

1. Contract Reserves

For all other group contract benefits, morbidity assumptions shall be determined as provided in this article.

2. Claim Reserves

For all benefits other than disability income, claim reserves shall be determined as provided in this article.

(b) Interest

(1) For contract reserves the maximum interest rate shall be the maximum rate permitted by Insurance Code § 10489.4 in the valuation of whole life insurance issued on the same date as the disability insurance contract.

(2) For claim reserves on policies that require contract reserves, the maximum interest rate shall be the maximum rate permitted by Insurance Code § 10489.4 in the valuation of whole life insurance issued on the same date as the claim incurral date.

(3) For claim reserves on policies not requiring contract reserves, the maximum interest rate shall be the maximum rate permitted by Insurance Code § 10489.4 in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points.

(c) Mortality

(1) Except as provided in paragraph (3), the mortality basis used for all policies, except long-term care individual policies and group certificates issued on or after January 1, 2005, shall be:

(i) for active lives according to a table (but without use of select factors) permitted by Insurance Code §10489.2(a) for the valuation of whole life insurance issued on the same date as the disability insurance contract;

(ii) for disabled lives the mortality basis, if any, shall be according to a table (but without select factors) permitted by Insurance Code §10489.2(a) for the valuation of whole life insurance issued on the same date as the claim incurred date.

(2) For long-term care insurance individual policies or group certificates issued on or after January 1, 2005, the morbidity basis used shall be the 1994 Group Annuity Mortality Static Table, which is Table 18 in 1995 Transactions of the Society of Actuaries, Volume 47, pp. 898–899, incorporated by reference herein.

(3) Other mortality rates may be used in the calculation of the minimum reserves, if appropriate for the type of benefits and if approved by the Commissioner. The request for such approval must include the proposed mortality basis and the reason that the standard specified in paragraph (1) or (2) is inappropriate.

NOTE: Authority cited: Sections 997(a) and 10489.95, Insurance Code. Reference: Sections 985, 997 and 10489.15(a), Insurance Code.

HISTORY

1. New section filed 11–4–94; operative 12–5–94 (Register 94, No. 44).
2. Amendment filed 12–13–2005; operative 12–13–2005 pursuant to Government Code section 11343.4 (Register 2005, No. 50).

Article 4. Experience and Reserves

§ 2318. California Workers' Compensation Unit Statistical Plan.

NOTE: Pursuant to the provisions of Government Code Section 11344, this regulation is not printed in full herein. The complete regulation may be examined at the offices of the Insurance Commissioner at San Francisco, Los Angeles, Sacramento, and San Diego; the Statistical Plan will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California, office.

NOTE: Authority cited: Sections 11751.5, Insurance Code. Reference: Sections 11740 and 11751.5, Insurance Code.

HISTORY

1. Amendment of Sections III, I, VI and Appendix filed 6–30–82; effective thirtieth day thereafter (Register 82, No. 27). For prior history, see Register 81, No. 50.

§ 2318.5. California Workers' Compensation Unit Statistical Plan.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344, this regulation is not printed in full herein. This complete regulation may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The statistical plan will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California office.

NOTE: Authority cited: Section 11751.5, Insurance Code. Reference: Sections 11740 and 1151.5, Insurance Code.

HISTORY

1. New section filed 1–21–81; designated effective 1–1–83 (Register 81, No. 4).
2. Amendment of sections I, II, III, IV, V and Appendices I–A and II–A through II–D filed 12–11–81; designated effective 1–1–83 (Register 81, No. 50).
3. Amendment of Introduction, sections II, III IV, and Appendix I filed 6–30–82; effective thirtieth day thereafter (Register 8, No. 27).
4. Amendment of section II filed 4–11–83; effective thirtieth day thereafter (Register 83, No. 16).
5. Amendment of sections I–III and Appendix II–B filed 12–30–83; designated effective 1–1–84 pursuant to Government Code section 11346.2(d) (Register 84, No. 1).
6. Amendment of sections II and IV filed 1–22–86; effective upon filing pursuant to Government Code section 11346.2(d) (Register 86, No. 4).
7. Amendment filed 5–4–87 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 5–4–87 (Register 87, No. 19).
8. Amendment adopted without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–88 (Register 88, No. 4).
9. Amendment filed 12–31–90 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–91 (Register 91, No. 6).
10. Amendment filed 12–31–92 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–93 (Register 93, No. 1).
11. Amendment filed 12–31–93 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–94 (Register 93, No. 53).
12. Editorial correction of section heading (Register 93, No. 53).
13. Repealer filed 12–30–94; effective date 1–1–95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995. Repealer filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).

§ 2318.6. California Workers' Compensation Uniform Statistical Reporting Plan — 1995.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344.6, this regulation is not printed in full herein. The complete regulation may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The complete regulation will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California office.

NOTE: Authority cited: Section 11751.5, Insurance Code. Reference: Sections 11730 and 11736, Insurance Code.

HISTORY

1. Adoption filed 12–30–94; effective 1–1–95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995. Adoption filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).
2. Amendments filed 12–15–95; operative 1–1–96. Amendments filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 95, No. 50).
3. Amendment filed 12–11–96; operative 1–1–97. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 96, No. 50).
4. Amendment filed 12–31–97; operative 1–1–98. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 98, No. 1).
5. Amendment filed 1–25–99; operative 1–1–99. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 99, No. 5).
6. Amendment filed 12–27–99; operative 1–1–2000. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 99, No. 53).
7. Amendment filed 12–29–2000; operative 1–1–2001. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2000, No. 52).
8. Amendment filed 1–10–2002 without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9) (Register 2002, No. 2).
9. Amendment filed 8–12–2002; operative 4–1–2002. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2002, No. 33).
10. Amendment filed 8–12–2002; operative 7–1–2002. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2002, No. 33).
11. Amendment filed 12–31–2002; operative 1–1–2003. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2003, No. 1).
12. Amendment filed 12–31–2003; operative 7–1–2003. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2004, No. 1).

13. Amendment filed 12–31–2003; operative 1–1–2004. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2004, No. 1).
14. Editorial correction updating editorial note (Register 2004, No. 38).
15. Amendment filed 9–16–2004; operative 7–1–2004. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2004, No. 38).
16. Amendment filed 3–2–2005; operative 1–1–2005. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2005, No. 9).
17. Amendment filed 10–20–2005; operative 7–1–2005. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2005, No. 42).
18. Amendment filed 6–19–2006; operative 1–1–2006. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2006, No. 25).
19. Amendment filed 9–20–2006; operative 7–1–2006. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2006, No. 38).
20. Amendment filed 4–16–2007; operative 1–1–2007. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2007, No. 16).
21. Amendment filed 10–31–2007; operative 7–1–2007. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2007, No. 44).
22. Amendment filed 6–16–2008; operative 1–1–2008. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2008, No. 25).

Article 4.5. Loss and Loss Expense Reserves

§ 2319. Authority.

These regulations are promulgated pursuant to the authority granted to the Commissioner under the provisions of Section 923.5 of the Insurance Code. These regulations shall apply to each insurer transacting business in this State but shall not apply to life insurance, disability insurance, title insurance, mortgage insurance, or mortgage guaranty insurance.

NOTE: Authority cited: Section 923.5, Insurance Code.

HISTORY

1. New Article 4.5 (§2319, 2319.1–2319.4) filed 2–6–76; effective thirtieth day thereafter (Register 76, No. 6).

§ 2319.1. Reserve Test Method.

(a) Every insurer shall immediately establish an effective method for testing the adequacy of loss and loss expense reserves previously established and reported in the annual statement.

(b) Such method shall include provision for the estimation of the current adequacy level.

(c) Such method must be adequately describe and shall include a description of the insurer's claim practices to the extent that they affect the data used in the reserve test method. Such description shall include, among other things, the definition of a late–reported claim, the definition of a reopened claim, changes in claim practices, the procedures used to verify that the tabulation of outstanding claims at a given date contains all of the files of open claims as of such date, and other pertinent information. This description is to be continuously updated and immediately available to the Commissioner on request.

(d) Such method shall provide a means of testing as of June 30 the adequacy of each calendar year's reserves previously established.

(e) The data must be fully reconcilable to annual statement type data.

(f) If a material deficiency is indicated by the reserve test method for the reserves as established, the insurer shall take corrective action prior to the preparation of the next subsequent annual statement.

(g) Such method shall also separately estimate the deficiencies in the reserves for reported claims.

§ 2319.2. Reserve Computation.

(a) Reserves shall reflect inflation and development projected to date of ultimate payment.

(b) Reserves shall include provisions for an appropriate incurred–but–not–reported (IBNR) reserve based on the experience of the insurer or where experience is lacking based on reasonable actuarial assumptions applied to other experience. The reserve computation shall, where appropriate, estimate the expected number of claims yet to be reported from accident years prior to a statement date together with the corresponding incurred amount. The calculation of such expected claims shall give due consideration to changes in the exposure base.

(c) Allocated and unallocated loss expense reserves shall be based on individual company experience or other reasonable evidence which measures the probable cost of liquidating claim liability. Ratios of paid expenses to paid losses may not be modified by arbitrary factors.

§ 2319.3. Minimum Reserves.

The minimum reserve requirements prescribed in Section 11558 shall be increased whenever the Commissioner determines that the computations set forth in Section 11558 are inadequate as provided by Section 11557. Such increases may be based on individual company experience or reasonable actuarial assumptions in the absence of such experience. The method used by the National Association of Insurance Commissioners for calculating the excess of statutory reserves over statement reserves in the annual statement is adopted for the minimum reserve requires of Section 11558 subject to such individual determination as the Commissioner shall make.

§ 2319.4. Records.

All records of the reserve method including reserve tests and reports shall be retained and made available for examiners of the Commissioner, and copies thereof shall also be furnished to the Commissioner on request.

Article 5. Marine Insurance

§ 2320. Effective Date; Construction of Provisions.

This article is effective January 1, 1954, and supersedes former Sections 2320, 2321 and 2322 which are hereby nullified. Insofar as the provisions of this article are substantially the same as the provisions of former Sections 2320, 2321 and 2322 prior to the effective date hereof they shall be construed as restatements and continuations thereof and not as new provisions.

NOTE: Authority cited: Sections 103, 12921, 12921.5, 12926, Insurance Code. Additional authority cited: Section 1851(c), Insurance Code.

HISTORY

1. Originally printed 5–15–46 (Register 3).
2. Repealer of Article 5 (§§ 2320 to 2322, inclusive), filed 11–30–53; designated effective 1–1–54; (Register 53, No. 22).

§ 2320.1. Purpose.

This article is adopted and promulgated by the Insurance Commissioner as a necessary means for the guidance of insurers and all other concerned in observing the provisions of law relating to: insuring powers of admitted marine insurers; the California Standard Form Fire Insurance policy; rates and rating and other organizations; taxation of insurers; and to assist in determining whether certain business should be reported on insurers' annual statements as ocean marine insurance or otherwise; and for the assistance and guidance of all persons concerned in all other cases where it is necessary to distinguish between marine and other classes of insurance and between inland marine risks, and other risks.

§ 2320.2. Scope.

Nothing in this article shall contravene, curtail or expand any statute; it is intended as a partial description of the kinds of risks and coverages presently regarded by the Insurance Commissioner as classifiable under

Insurance Code Section 103. It is not an exhaustive or complete enumeration of risks and coverages which may be so classified. Inclusion herein shall not be construed as indicating that such risks and coverages are solely marine insurance. Nothing in this article shall be construed as binding or limiting any discretion or power conferred upon the Insurance Commissioner by the Legislature.

§ 2321.

Marine and/or transportation policies may cover under the following conditions:

(a) Imports

(1) Imports on consignment may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation. A shipment "on consignment" shall mean property consigned and intrusted to a factor or agent to be held in his care, or under his control for sale for account of another or for exhibit or trial or approval or auction, and if not disposed of, to be returned.

(2) Imports not on consignment in such places of storage as are usually employed by importers, provided the coverage of the issuing companies includes hazards of transportation. Such policies may also include the same coverage in respect to property purchased on C.I.F. terms or "spot" purchases for inclusion with or in substitution for bona fide importations. An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such so long as the property remains segregated in the original form or package in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:

(A) Sold and delivered by the importer, factor or consignee; or

(B) Removed from place of storage as described in paragraph "2" above and placed on sale as part of importer's stock in trade at a point of sale–distribution; or

(C) Delivered for manufacture, processing or change in form to premises of the importer or of another used for any such purposes.

(b) Exports

(1) Exports may be covered wherever the property may be without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation. An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this article respecting domestic shipments shall apply, provided, however, that this provision shall not apply to long established methods of insuring certain commodities, e.g., cotton.

(c) Domestic Shipments

(1) Domestic shipments on consignment, provided the coverage of the issuing companies includes hazards of transportation.

(A) Property shipped on consignment for sale or distribution, while in transit and not exceeding one hundred and twenty (120) days after arrival at consignee's premises or other place of storage or deposit; and

(B) Property shipped on consignment for exhibit, or trial, or approval, or auction, while in transit, while in the custody of others and while being returned.

(2) Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by assured or purchaser, not for more than ninety (90)days at other place of storage or deposit, except in premises of transportation companies or freight forwarders, when such storage is incident to transportation.

(d) Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion are the only hazards to be covered. Piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion. Other aids to navigation and transportation, including dry docks and marine railways, against all risks. The foregoing includes:

(1) Bridges, tunnels, other similar instrumentalities, unless fire, lightning, windstorm, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion are the only perils to be covered.

(2) Piers, wharves, docks and slips, but excluding the risks of fire, lightning, windstorm, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion.

(3) (A) Pipelines, including on–line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.

(B) Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.

(4) Radio and television communication equipment in commercial use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus but excluding buildings, their improvements and betterments, furniture and furnishings and supplies held in storage therein.

(5) Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.

(e) Personal Property Floater Risks

(1) Covering Individuals.

(A) Tourists Floater, Personal Effects Floater Policies.

(B) The Personal Property Floater.

(C) Government Service Floaters.

(D) Personal Fur Floaters.

(E) Personal Jewelry Floaters.

(F) Wedding Present Floaters for not exceeding ninety (90) days after the date of the wedding.

(G) Silverware Floaters.

(2) Covering Individuals and/or Generally.

(A) Fine Arts Floaters, Stamp and Coin Floaters. To cover objects of art such as pictures, statuary, bronzes and antiques, rare manuscripts and books, articles of virtu, etc.

(B) Musical Instrument Floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(C) Radium Floaters.

(D) Physicians' and Surgeons' Instrument Floaters. Such policies may include coverage of such furniture, fixtures and tenant assured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the assured in the practice of his profession.

(E) Pattern and Die Floaters, excluding coverage on the owner's premises.

(F) Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.

(G) Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.

(H) Salesmen's Samples Floaters.

(I) Jewelers' Block Policies, including tenant assured's interest in improvements and betterments of buildings, furniture, fixtures, tools, machinery, patterns, molds and dies.

(J) Exhibition Policies on property while on exhibition and in transit to or from such exhibitions.

(K) Live Animal Floaters, covering wherever animals, wagons and mobile equipment may be.

(L) Installation risks, covering machinery and equipment including plumbing, heating, cooling and electrical systems (as distinguished from building materials) while in transit to place of installation and during the period of installation and testing. Coverage must cease:

(1) where such property is insured for the account of the seller or installer,when the interest of such insured ceases; or,

(2) in no case later than when such property has been accepted as satisfactory; whichever first occurs, as to (1) or (2).

Building materials (e.g., structural steel, lumber, bricks and mortar), while in transit to place of installation and after arrival thereat but such coverage must terminate when the materials are installed and have become a physical part of the realty or when the seller's interest ceases, whichever first occurs.

(M) Mobile Articles, Machinery and Equipment Floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semitrailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use), covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into the custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

(N) Property in transit to or from and in the custody of

(1) Bleacheries, throwsters, fumigatories, dyers, cleaners, laundries, and similar bailees;

(2) Needleworkers;

(3) Other bailees (not owned, controlled or operated by the bailor) for the purpose of performing work thereon (as distinguished from the making of a complete article) including the treatment of, or assemblage, of property on the premises of bailees. Such policies shall not cover bailee's property at his premises.

(O) Installment Sales and Leased Property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This section is not intended to include machinery and equipment under certain "lease–back" contracts.

(P) Garment Contractors Floaters.

(Q) Furriers or Fur Storer's Customer's Policies (i.e., policies under which certificates or receipts are issued for furriers or fur storers) covering specified articles the property of customers.

(R) Accounts Receivable Policies, Valuable Papers and Records Policies.

(S) Cold Storage Locker Plant Policies, covering merchandise of customers consisting principally of meats, game, fish, poultry, fruit, vegetables and property of a similar nature.

(T) Floor Plan Policies, covering property for sale while in possession of dealers under a floor plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:

(1) Such merchandise is specifically identifiable as encumbered to the bank or lending institution.

(2) The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.

(3) That such policies cover in transit and do not extend beyond the termination of the dealer's interest. Provided that such policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.

(U) Sign and Street Clock Policies, covering neon signs, automatic or mechanical signs, street clocks, while in use as such.

(V) The following policies covering property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under Inland Marine Policies:

(1) Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, Telephones, recordplayers and combinations thereof are not deemed musical instruments.

(2) Camera Dealers Policies, covering property consisting principally of cameras and their accessories.

(3) Furrier's Dealers Policies, covering property consisting principally of furs and fur garments.

(4) Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefor; construction equipment consisting of bulldozers, roadscrapers, tractors, compressors, pneumatic tools and similar equipment and accessories thereof; but excluding motor vehicles designed for highway use. All such policies shall exclude coverage of moneys and securities. Such policies may include coverage of tenant assured's interest in improvements and betterments of buildings,furniture, fixtures, tools, machinery, patterns, molds and dies.

(W) Wool Growers Floaters.

(X) Domestic Bulk Liquids Policies, covering domestic bulk liquids stored in tanks provided the risks of fire and inherent explosion, windstorm, sprinkler leakage, earthquake, hail, explosion, riot or civil commotion are excluded therefrom.

(Y) Furniture Shipment Policies, covering furniture, fixtures and equipment in bona fide course of shipment from one location to another location of the owner including in place of deposit incident to such transportation while awaiting determination or availability of final destination, in which event they must cover at time of issuance transportation to or from such place of deposit but may not cover after delivery at destination.

HISTORY

1. Amendment filed 5–31–66; effective thirtieth day thereafter (Register 66, No. 16). For prior history, see Register 61, No. 11.

§ 2322. Prohibited Coverage.

Unless otherwise permitted, nothing in the foregoing shall be construed to permit marine or transportation policies to cover:

(a) Storage of assured's merchandise, except as herein before provided.

(b) Merchandise in course of manufacture, the property of and on the premises of the manufacturer.

(c) Furniture and fixtures and improvements and betterments to buildings.

(d) Merchandise in permanent location, sold under partial payment, contract of sale, or installment sales contract, which involves protection of the purchaser's interest after seller's interest ceases.

(e) Moneys and/or securities in safes, vaults, safety deposit vaults, banks or assured's premises, except while in course of transportation.

(f) Risks of fire, windstorm, sprinkler leakage, earthquake, hail, explosion, riot, and/or civil commotion on buildings, structures, wharves, piers, docks, bulkheads and sheds and other fixed real property on land and/or over water, except as herein before provided.

Article 6. Taxation

§ 2324. Reporting and Allocating Risks in Federal Areas.

(a) Every insurance company or association doing business in this State is hereby required to include in its premium tax return to this department for the years 1941, et seq., all premiums received by it during each of said years upon insurance business done in all federal areas located within the exterior boundaries of the State of California.

(b) Where premiums for insurance upon the lives or health of members of the armed forces or their families are collected directly from the fiscal officer of either branch of the service under salary allotment authorizations, such premiums are to be allocated to California:

(1) In cases where the insurance was in force prior to the entry into the armed service and the last premium previous to such entry was allocable

to California under the normal and usual rules for allocation of premiums.

(2) In cases of all insurance originating in federal areas located within the exterior boundaries of the State of California when, because of the peculiar status of military personnel with respect to established residence, the normal rules for allocation of premiums are impossible or impractical of application, for so long as such conditions continue to exist.

(c) The fact that premiums are collected under salary allotment authorizations does not of itself render them exempt from such tax to which they are otherwise subject under the statutes quoted, as herein construed and interpreted. (Pol. Code Sections 34, 3666a, 54 U.S. Stats., p. 1059, 4 U. S. C. A. 13a)

§ 2325. Filing Statement for Computation of Retaliatory Tax.

Annually, on or before May 1st, every foreign insurer engaged in the business of insurance in the State of California in the preceding calendar year shall file with the Insurance Commissioner a statement in the form prescribed by him setting forth such information as will permit the commissioner to properly administer the retaliatory provisions of Article 1.5, Chapter 1, Part 2, Division 1 (Sections 685–685.4) of the Insurance Code. The commissioner may waive such filing with respect to the insurers of a state or province or of any class of insurers of a state or province if he determines after an analysis of the laws of such state or province relating to taxes, licenses and fees and their application by that state or province and of such laws of the State of California and their application that under no circumstances will a retaliatory tax be due from such insurers.

NOTE: Authority cited: Section 685.3, Insurance Code. Reference: Sections 685–685.4, Insurance Code.

HISTORY

1. New section filed 2–19–60 as an emergency; effective upon filing (Register 60, No. 4).
2. Amendment filed 4–26–60; effective thirtieth day thereafter (Register 60, No. 10).

Article 6.5. Guidelines for Waiver of Penalty for Non–Use of Electronic Funds Transfer or for Non–Timely Payment of Taxes

§ 2330.1. Electronic Funds Transfer Penalties.

Insurers and surplus line brokers (hereafter, "taxpayers") are required to make payment by Electronic Funds Transfer ("EFT") if their annual taxes exceed twenty thousand dollars ($20,000). If they fail to make payment by some method other than EFT or the payment is not timely, they will be assessed a ten percent penalty plus interest on the amount due unless the penalty is waived as set forth under Sections 2330.3 and 2330.4. If taxpayers make payment by some method other than EFT and the payment is not timely, taxpayers will be assessed a twenty percent penalty plus interest on the amount due unless the penalty is waived as set forth under Sections 2330.3 and 2330.4.

NOTE: Authority cited: Sections 1775.4(e), 1775.5(b), 1775.8 and 12976.5(a), Insurance Code; and Sections 12602(c)(1), 12631 and 12636, Revenue and Taxation Code. Reference: Sections 45, 1775.4, 1775.5, 1775.8 and 12976.5, Insurance Code; and Sections 12602 and 12631, Revenue and Taxation Code.

HISTORY

1. New article 6.5 (sections 2330.1–2330.5) and section filed 7–21–2008; operative 8–20–2008 (Register 2008, No. 30).

§ 2330.3. Waiver of Penalty for Failure to Pay Taxes by EFT.

(a) The penalty set forth above in Section 2330.1 may be waived if the taxpayer's failure to pay taxes by EFT is due to reasonable cause or circumstances beyond the taxpayer's control.

(b) In order for the penalty to be waived, the taxpayer seeking a waiver must file with the Insurance Commissioner a written request under penalty of perjury, stating the facts upon which a request for a waiver is based. Each request for a waiver shall be evaluated on its own merits.

(c) The request for a waiver shall be granted if the taxpayer fails to make payment by electronic funds transfer under any of the following circumstances:

(1) The death or serious illness of the taxpayer or death or serious illness of a member of the taxpayer's immediate family.

(2) The death or serious illness of the person who prepares the payment on behalf of the taxpayer.

(3) Natural disaster.

(4) Incorrect advice given to the taxpayer by an employee of the Commissioner.

(5) Involuntary bankruptcy.

(6) An attachment placed against the taxpayer's bank account without the taxpayer's knowledge.

(7) The taxpayer's books and records are impounded by court order or are in the hands of a federal or state agency and are unavailable for use by the taxpayer. However, these books and records must pertain to the same period of time as the tax return or somehow relate to the payment of the tax.

(8) If the State of California does not suffer any financial loss as a result of the payment method and the taxpayer was not previously notified of the electronic funds transfer method. The taxpayer shall work with the Department of Insurance to establish an electronic funds transfer method.

(9) Other situations that clearly demonstrate that the non–use of EFT is beyond the taxpayer's control.

NOTE: Authority cited: Sections 1775.4(e), 1775.5(b), 1775.8(c)(2) and 12976.5(c)(2), Insurance Code: and Section 12602(c)(2), Revenue and Taxation Code. Reference: Sections 1775.4(e), 1775.5(b), 1775.8(c)(2) and 12976.5(c)(2), Insurance Code; and Section 12602, Revenue and Taxation Code.

HISTORY

1. New section filed 7–21–2008; operative 8–20–2008 (Register 2008, No. 30).

§ 2330.4. Waiver of Penalty for Failure to Timely Make Payment.

(a) The penalty set forth above in Section 2330.1 may be waived if the surplus line broker fails to make a timely payment under any of the circumstances set forth under Section 2330.3(c)(1) through (7) above. A surplus line broker may also be relieved of the penalty for late payment if:

(1) the surplus line broker failed to receive a tax return because of a change of address and the Department has been properly informed of the change of address.

(2) for any other reason, the surplus line broker has not received a tax return from the Department where the Department is at fault.

(3) other situations that clearly demonstrate that failure to make timely payment is beyond the surplus line broker's control.

NOTE: Authority cited: Sections 1775.4(e) and 1775.5(b), Insurance Code. Reference: Sections 1775.4(e) and 1775.5(b), Insurance Code.

HISTORY

1. New section filed 7–21–2008; operative 8–20–2008 (Register 2008, No. 30).

§ 2330.5. Filing for Relief.

(a) Any surplus line broker seeking to be relieved of the penalty provided in Section 2330.1 for failure to pay taxes by EFT and/or failure to timely make a payment shall file with the Department a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(b) Any insurer seeking to be relieved of the penalty provided in Section 2330.1 for failure to pay taxes by EFT shall file with the Department a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(c) Any insurer seeking to be relieved of the penalty provided in Section 2330.1 for failure to timely make a payment shall file with the California Board of Equalization a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

NOTE: Authority cited: Sections 1775.4(e), 1775.5(b), 1775.8(b)(2), 1775.8(c)(3) and 12976.5(c)(2), Insurance Code; and Section 12602(c)(3), Revenue and Taxa-

tion Code. Reference: Sections 1775.4(e), 1775.5(b), 1775.8(b)(2), 1775.8(b)(3) and 12976.5(c)(2), Insurance Code; Sections 12602(c)(3) and 12631, Revenue and Taxation Code.

HISTORY

1. New section filed 7–21–2008; operative 8–20–2008 (Register 2008, No. 30).

Article 7. Rates and Rating Systems

NOTE: The Insurance Commissioner has approved the manuals named in this Article 7. These manuals are filed but for the present are separately published, not as part of the California Administrative Code. Those manuals not printed herein may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento and San Diego. The manuals will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California, office.

§ 2350. Rules, Classifications and Basic Rates for Workers' Compensation Insurance.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344, this regulation is not printed in full herein. This manual may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The manual will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California office.

NOTE: Authority cited: Section 11734, Insurance Code. Reference: Sections 11732, 11732.1 and 11734, Insurance Code.

HISTORY

1. Amendment filed 4–8–87; effective 1–1–87 pursuant to Government Code section 11343(a)(1) set new rates effective with respect to all new policies with an inception date on or after January 1, 1987 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1987. (Register 87, No. 16). For prior history see Register 86, No. 43.
2. Amendment filed 5–4–87 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 5–4–87 (Register 87, No. 19).
3. Editorial correction of HISTORY 8 deleting reference to printing the text of section 2350 in full. The text of section 2350 is incorporated by reference; see EDITORIAL NOTE (Register 87, No. 23).
4. Amendment filed 7–2–87 pursuant to Government Code section 11346.2 (d) (Register 87, No. 29).
5. Amendment filed 9–16–87 pursuant to Government Code section 11346.2 (d) (Register 87, No. 38).
6. Amendment adopted without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–88 (Register 88, No. 4).
7. Amendment filed 12–15–88 with the Secretary of State without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–89 (Register 88, No. 53).
8. Amendment filed 12–21–89 with the Secretary of State without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–90 (Register 90, No. 1).
9. Amendment filed 3–8–90 with the Secretary of State without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 3–1–90 (Register 90, No. 12).
10. Amendment filed 12–31–90 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–91 (Register 91, No. 6).
11. Amendment filed 8–4–92 pursuant to Government Code section 11343.8; operative 7–1–92 (Register 92, No. 32).
12. Amendment filed 12–31–92 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–93 (Register 93, No. 1).
13. Amendment filed 12–31–93 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–94 (Register 93, No. 53).
14. Editorial correction of section heading (Register 93, No. 53).
15. Amendment filed 11–22–94 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 10–1–94 (Register 94, No. 47).
16. Repealer filed 12/30/94; effective 1–1–95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995. Repealer filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).

§ 2351. Industrial Compensation Rating Schedule.

HISTORY

1. Repealer filed 8–31–73; designated effective with respect to schedule ratings becoming effective on or after October 1, 1973 (Register 73, No. 35). For prior history, see Registers 72, No. 7; 70, No. 34; 69, No. 32; 68, No. 33. Original filing date: 5–10–46.

§ 2351.1. Chemical and Dyestuff Rating Plan.

HISTORY

1. Repealer filed 8–28–68; designated effective with respect to all new policies with an inception date falling on or after 10–1–68, and with respect to all renewal policies as of the first normal anniversary date falling on or after 10–1–68 (Register 68, No. 33). For prior history, see Registers 64, No. 18; 62, No. 16; 58, No. 12. Original filing date: 7–10–58.

§ 2351.2. Pneumonoconiosis Schedule Rating Plan.

HISTORY

1. Repealer filed 8–31–73; designated effective with respect to pneumonoconiosis schedule ratings becoming effective on or after October 1, 1973 (Register 72, No. 35). For prior history, see Registers 68, No. 33; 67, No. 38; 67, No. 35; 66, No. 24; 64, No. 18; 62, No. 16; 61, Nos. 6 and 15; 60, No. 19; 58, No. 12. Original filing date: 7–10–58.

§ 2352. Retrospective Rating Plan, Workmen's Compensation Insurance.

HISTORY

1. Repealer filed 8–29–57; designated effective 10–1–57 (Register 57, No. 14). For prior history, see Registers 53, No. 5; 29, No. 2.

§ 2352.1. California Workers' Compensation Retrospective Rating Plan.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344, this regulation is not printed in full herein. This manual may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The manual will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California, office.

NOTE: Authority cited: Sections 11732, 11732.1 and 11734, Insurance Code. Reference: Sections 11732, 11732.1 and 11734, Insurance Code.

HISTORY

1. Amendment filed 8–13–75; designated effective with respect to retrospective ratings becoming effective on or after October 1, 1975 (Register 75, No. 33). For prior history see Register 74, No. 35.
2. Amendment filed 11–12–76; designated effective with respect to retrospective ratings becoming effective on or after January 1, 1977 (Register 76, No. 46).
3. Amendment filed 5–25–77; designated effective with respect to retrospective ratings becoming effective on or after September 1, 1977 (Register 77, No. 22).
4. Amendment filed 12–1–78; designated effective with respect to retrospective ratings becoming effective on or after January 1, 1979 (Register 78, No. 48).
5. Amendment filed 12–14–79 as an emergency; designated effective with respect to retrospective ratings becoming effective on or after January 1, 1980. Certificate of Compliance included (Register 79, No. 50).
6. Amendment filed 1–21–81; effective thirtieth day thereafter (Register 81, No. 4).
7. Amendment filed 12–30–83; designated effective 1–1–84 pursuant to Government Code section 11346.2(d) with respect to retrospective ratings becoming effective on or after January 1, 1984 (Register 84, No. 1).
8. Amendment filed 12–21–84; designated effective 1–1–85 pursuant to Government Code section 11346.2(d) with respect to retrospective ratings becoming effective on or after January 1, 1985 (Register 85, No. 1).
9. Amendment filed 1–22–86; effective upon filing pursuant to Government Code section 11346.2(d) with respect to retrospective ratings becoming effective on or after January 1, 1986 (Register 86, No. 4).
10. Amendment filed 5–4–87 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 5–4–87 (Register 87, No. 19).
11. Amendment adopted without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–88 (Register 88, No. 4).
12. Amendment filed 12–31–90 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–91 (Register 91, No. 6).

13. Repealer filed 12–30–94; effective 1–1–95 with respect to retrospective ratings becoming effective on or after January 1, 1995. Repealer filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).

§ 2353. Experience Rating Plan, Workers' Compensation Insurance.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344, this regulation is not printed in full herein. This manual may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The manual will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California, office.

NOTE: Authority cited: Sections 11732, 11732.1 and 11734, Insurance Code. Reference: Sections 11732, 11732.1 and 11734, Insurance Code.

HISTORY

1. Amendment filed 12–30–83; designated effective 1–1–84 pursuant to Government Code section 11346.2(d) with respect to experience ratings becoming effective on or after January 1, 1984 (Register 84, No. 1) . For prior history, see Register 83, No. 1.
2. Amendment filed 12–21–84; designated effective 1–1–85 pursuant to Government Code section 11346.2(d) with respect to experience ratings becoming effective on or after January 1, 1985 (Register 85, No. 1).
3. Amendment filed 1–22–86; effective upon filing pursuant to Government Code section 11346.2(d) with respect to experience ratings becoming effective on or after January 1, 1986 (Register 86, No. 4).
4. Amendment filed 5–4–87 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 5–4–87 (Register 87, No. 19).
5. Amendment adopted without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343) ; operative 1–1–88 (Register 88, No. 4).
6. Amendment filed 12–15–88 with the Secretary of State without OAL review pursuant to exemption for regulations which establish or fix rates (Government code section 11343) ; operative 1–1–89 (Register 88, No. 53).
7. Amendment filed 12–21–89 with the Secretary of State without OAL review pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–90 (Register 90, No. 1).
8. Amendment filed 12–31–90 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–91 (Register 91, No. 6).
9. Amendment filed 12–31–92 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–93 (Register 93, No. 1).
10. Amendment filed 12–31–93 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 1–1–94 (Register 93, No. 53).
11. Amendment filed 11–22–94 with the Secretary of State without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343); operative 10–1–94 (Register 94, No. 47).
12. Repealer filed 12–30–94; effective 1–1–95 with respect to experience ratings becoming effective on or after January 1, 1995. Repealer filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).

§ 2353.1. California Workers' Compensation Experience Rating Plan — 1995.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344.6, this regulation is not printed in full herein. The complete regulation may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The complete regulation will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California office.

NOTE: Authority cited: Section 11734, Insurance Code. Reference: Sections 11730 and 11736, Insurance Code.

HISTORY

1. Adoption filed 12–30–94; effective 1–1–95 with respect to experience ratings with effective dates on or after January 1, 1995. Adoption filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).
2. Amendment filed 1–2–96; operative 1–2–96. Amendment filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343) (Register 96, No. 1).
3. Amendment filed 12–11–96; operative 1–1–97. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates (Government Code section 11343) (Register 96, No. 50).
4. Amendment filed 12–31–97; operative 1–1–98. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 98, No. 1).
5. Amendment filed 7–21–98; operative 1–1–98. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 98, No. 30).
6. Amendment filed 1–25–99; operative 1–1–99. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 99, No. 5).
7. Amendment filed 12–27–99; operative 1–1–2000. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 99, No. 53).
8. Amendment filed 12–29–2000; operative 1–1–2001. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2000, No. 52).
9. Amendment filed 1–10–2002 without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9) (Register 2002, No. 2).
10. Amendment filed 8–12–2002; operative 4–1–2002. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2002, No. 33).
11. Amendment filed 12–31–2002; operative 1–1–2003. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2003, No. 1).
12. Amendment filed 12–31–2003; operative 7–1–2003. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2004, No. 1).
13. Amendment filed 12–31–2003; operative 1–1–2004. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2004, No. 1).
14. Editorial correction updating editorial note (Register 2004, No. 38).
15. Amendment filed 9–16–2004; operative 7–1–2004. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2004, No. 38).
16. Amendment filed 3–2–2005; operative 1–1–2005. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2005, No. 9).
17. Amendment filed 10–20–2005; operative 7–1–2005. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2005, No. 42).
18. Amendment filed 6–19–2006; operative 1–1–2006. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2006, No. 25).
19. Amendment filed 9–20–2006; operative 7–1–2006. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2006, No. 38).
20. Amendment filed 4–16–2007; operative 1–1–2007. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2007, No. 16).
21. Amendment filed 10–31–2007; operative 7–1–2007. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2007, No. 44).
22. Amendment filed 6–16–2008; operative 1–1–2008. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2008, No. 25).

§ 2354. Recording and Reporting of Data.

EDITORIAL NOTE: Pursuant to the provisions of Government Code section 11344, this regulation is not printed in full herein. The complete regulation may be examined at the offices of the Insurance Commissioner in San Francisco, Los Angeles, Sacramento, and San Diego. The complete regulation will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its San Francisco, California office.

NOTE: Authority cited: Section 11751.5, Insurance Code. Reference: Sections 11730 and 11734, Insurance Code.

HISTORY

1. Adoption filed 12–30–94; effective 1–1–95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995. Adoption filed without review by OAL pursuant to exemption for regulations which establish or fix rates (Government Code section 11343). (Register 94, No. 52).
2. Amendments filed 12–15–95; operative 1–1–96. Amendments filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 95, No. 50).
3. Amendment filed 12–29–2000; operative 1–1–2001. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2000, No. 52).
4. Amendment filed 12–31–2002; operative 1–1–2003. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2003, No. 1).
5. Amendment filed 12–31–2003; operative 1–1–2004. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11343) (Register 2004, No. 1).
6. Amendment filed 3–2–2005; operative 1–1–2005. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2005, No. 9).
7. Amendment filed 10–20–2005; operative 7–1–2005. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2005, No. 42).
8. Amendment filed 6–19–2006; operative 1–1–2006. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices or tariffs (Government Code section 11340.9(g)) (Register 2006, No. 25).
9. Amendment filed 4–16–2007; operative 1–1–2007. Amendment filed without review by OAL pursuant to the exemption for regulations which establish or fix rates, prices, or tariffs (Government Code section 11340.9(g)) (Register 2007, No. 16).

Article 7.1. Title Insurance Statistical Plan and Related Rules Governing Rates and Charges

Subarticle 1. General Provisions and Definitions

§ 2355.1. Purpose.

This article is adopted to implement the provisions of chapter 1 of part 6 of division 2 of the Insurance Code that relate to the rate–regulatory laws pertaining to the business of title insurance. The purpose of this article includes, but is not limited to, the establishment of rules governing the reporting of financial data and the filing, review, and use of rates and premiums charged for the business of insurance in this state to the end that such rates shall not be excessive, inadequate, or unfairly discriminatory.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New article 7.1 (subarticles 1–5, sections 2355.1–2359.7), subarticle 1 (sections 2355.1–2355.8) and section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.2. Scope.

This article applies to every title insurer, underwritten title company, and controlled escrow company doing business in this state.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.3. Definitions.

(a) "Adjusted total" means the corrected total multiplied by the ratio of the expense inflation factor to the productivity growth factor.

(b) "Advisory organization" means an entity satisfying the definition of Insurance Code Section 12340.8, that is in compliance with Insurance Code Sections 12402 through 12402.2, and that has been designated by the Commissioner pursuant to Insurance Code Section 12401.5.

(c) "Amount of insurance" means the maximum liability under the policy of title insurance.

(d) "Calculated total" means the sum of the reported data.

(e) "Concurrent policy" means a second (or subsequent) policy issued by a title insurance company or its affiliate at or around the same time that the title insurance company issues the first title insurance policy in the transaction.

(f) "Conveyancing fees" means the fee charged by a public entity for the act of recording a deed, deed of trust, mortgage, lease, or other written instrument for the purpose of effecting the sale, transfer, encumbrance, or lease of real property.

(g) "Corrected total" means the calculated total corrected by the Commissioner in his discretion for missing and erroneous data.

(h) "Date of application" means the date on which the rate filing is stamped "Received" by the Department of Insurance Rate Filing Bureau.

(i) "Effective date" means the date that a filed rate is scheduled for use by a title insurer, underwritten title company, or controlled escrow company. Except as provided in Insurance Code Section 12401.71, an effective date for a filed rate shall be no earlier than the 30th day following the Commissioner's receipt of the filed rate. Any title insurer, underwritten title company or controlled escrow company that seeks to implement a reduction from an existing rate in accordance with Insurance Code Section 12401.71 shall demonstrate that the reduction from an existing rate meets the definition of a "rate decrease" as provided in this section.

(j) "Effective period" means the twelve–month period commencing on the effective date of the rate filing.

(k) "Escrow transaction" means the opening of a full escrow, whether or not escrow closes.

(*l*) "Full escrow" means the complete set of escrow activities associated with a typical residential transaction, including, at a minimum: serving as the liaison to all parties in the transaction; preparing escrow instructions; requesting a preliminary title search or title commitment to determine the present condition of title to the property; complying with the lender's requirements as specified in the escrow agreement; receiving purchase funds from the buyer; preparing or securing the deed or other documents related to escrow; prorating taxes, interest, insurance and rents according to instructions; securing releases of all contingencies or other conditions required; recording deeds and any other documents as instructed; closing escrow when all instructions from buyer and seller have been carried out; disbursing authorized funds; and preparing final statement.

(m) "Historical period" means the most recent year for which totals from the statistical plan are available.

(n) "Inspection fees" means the charge by a person engaged in the business of title insurance for the physical inspection, and report thereon, of real property. The charge for a survey of property boundaries is not included in "inspection fees."

(o) "Miscellaneous charges" means conveyancing fees, notary fees, inspection fees, and tax service contract fees.

(p) "Non–purchase other–than–refinancing transaction" means a non–purchase transaction other than a refinancing transaction.

(q) "Non–purchase refinancing transaction" means a non–purchase transaction in which a first mortgage or equivalent loan is satisfied.

(r) "Non–purchase transaction" means a transaction other than a purchase transaction.

(s) "Notary fees" means the fees charged by a notary public for the service of certifying and acknowledging signatures in the course of transacting the business of title insurance.

(t) "Other services" means a service or product related to the business of title insurance other than a preliminary report, a title insurance policy, full escrow, or subescrow.

(u) "Preliminary report transaction" means the order of a preliminary title report, whether or not a title insurance policy subsequently issues on the transaction that is the subject of the preliminary report.

(v) "Publish" means to promulgate and to post on the Department of Insurance web site, www.insurance.ca.gov.

(w) "Purchase transaction" means a transaction in which ownership of residential property changes hands.

(x) "Rate decrease" means a filing for a rate change the effect of which is to lower rates. An application that increases any rates covered by the application does not constitute a rate decrease.

(y) "Region" means:

(1) "South" in the case of the Counties of Kern, Los Angeles, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, and Ventura;

(2) "Bay Area" in the case of the Counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, and Sonoma; and

(3) "Rest of State" for all other counties.

(z) "Residential property" means any real property containing four or fewer dwelling structures, an individually owned unit in a common interest development as defined in Civil Code Section 1351, subdivision (c), or an individually owned piece of real property where the same individual maintains a registered mobile home. A residential property, for purposes of this definition, must be located in this state and used primarily for residential purposes. Unimproved land purchased for the purpose of erecting four or fewer dwelling structures on that land is included in this definition of "residential property."

(aa) "Subescrow" means funds transfer for lenders in those situations where another entity, typically an independent escrow company, is performing other escrow activities.

(bb) "Tax service contract fees" means the amount charged for the service of monitoring property tax payments on a residential property for the purpose of notifying a mortgagee, in the event that the subject property's taxes become delinquent.

(cc) "Title insurance company" means a title insurer, an underwritten title company, or a controlled escrow company.

(dd) "Title insurance transaction" means the sale of a residential property or the refinancing of a mortgage for a residential property associated with the issuance of a title insurance policy or policies.

(ee) "Unusual risk" means coverage for a title insurance policy peril that is not covered by a standard form or endorsement and for which a charge in excess of filed rates is made pursuant to Insurance Code Section 12401.8.

(ff) "Unusual service" means a service in the business of title insurance that is not part of a preliminary report, title insurance policy, full escrow, subescrow or other service filed with the Department and for which a charge in excess of filed rates is made pursuant to Insurance Code Section 12401.8.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1, 12401.2, 12401.71, 12401.8, 12402–12402.2, Insurance Code; and Section 1351, Civil Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.4. Projection Factors.

(a) "Expense inflation factor" means 1 plus the last 12 months' percent change in the consumer price index reported by the Bureau of Labor Statistics for all urban consumers (Series CUUR0000SA0, not seasonally adjusted, U.S. city average, all items) for the historical period.

(b) "Productivity growth factor" means 1 plus the 12 months' percent change in productivity reported most recently by the Bureau of Labor statistics for nonfarm businesses for the historical period.

(c) "Historical existing home sales" (HistExistSales) means the actual number of existing home sales in California as reported by the California Association of Realtors for the historical period.

(d) "Forecasted existing home sales" (FcstExistSales) means the forecast (as of the date of filing) of the number of existing–home sales in the effective year reported by the California Association of Realtors. If there is no such reported forecast, "forecasted existing home sales" means the forecast for the latest available 12–month period from the California Association of Realtors.

(e) "Historical new home sales" (HistNewSales) means the actual number of new home sales in California as reported by the California Department of Finance for the historical period.

(f) "Forecasted new home sales" (FcstNewSales) means the forecast (as of the date of filing) of the number of new home sales in the effective year reported by the California Department of Finance. If there is no such reported forecast, "forecasted new home sales" means the forecast for the latest available 12–month period from the California Department of Finance.

(g) "Historical refinancings" (HistRefis) means the actual number of mortgage originations for refinancings in California as reported by the Mortgage Bankers Association for the historical period.

(h) "Forecasted refinancings" (FcstRefis) means the forecast (as of the date of application) of mortgage originations for refinancings in the effective year reported by the Mortgage Bankers Association. If there is no such reported forecast, "forecasted refinancings" means the forecast for the latest year available from the Mortgage Bankers Association.

(i) "Historical transactions" (HistoricalTrans) means the sum of the historical new home sales, historical existing home sales, and the historical refinancings.

(j) "Forecasted transactions" (ForecastTrans) means the sum of the forecasted new home sales, forecasted existing home sales, and the forecasted refinancings.

(k) "Transactions growth factor" (TransGrowthFactor) means

(1) the ratio of the forecasted transactions (ForecastTrans) to the number of transactions for the historical period (HistoricalTrans)

(2) raised to the quantity n, which is the number of months between the midpoint of the period on which the weighted median home value forecast is based and the midpoint of the historical period, divided by 12.

Stated as an equation:

$$TransGrowthFactor = \left(\frac{ForecastTrans}{HistoricalTrans} \right)^{\frac{n}{12}}$$

(l) "Historical existing home median value" (HistExistValue) means the actual median value of existing home sales in California as reported by the California Association of Realtors for the historical period.

(m) "Forecasted existing home median value" (ForecastExistValue) means the forecast (as of the date of filing) of the median value of existing–home sales in California for the effective period as reported by the California Association of Realtors. If there is no such reported forecast,

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"forecasted existing home median value" means the forecast for median value of existing home sales in California as reported by the California Association of Realtors for the latest available 12–month period.

(n) "Historical new home median value" (HistNewValue) means the actual median value of new home sales in California as reported by the California Department of Finance for the historical period.

(o) "Forecasted new home median value" (FcstNewValue) means the forecast (as of the date of filing) of the median value of new home sales in California for the effective period as reported by the California Department of Finance. If there is no such reported forecast, "forecast new home median value" means the forecast for median value of new home sales in California as reported by the California Department of Finance for the latest available 12–month period.

(p) "Historical refinancings median value" (HistRefiValue) means the actual median value of mortgage originations for refinancings in California as reported by the Mortgage Bankers Association for the historical period.

(q) "Forecasted refinancings median value" (FcstRefiValue) means the forecast (as of the date of filing) of the median value of mortgage originations for refinancings in California for the effective period as reported by the Mortgage Bankers Association. If there is no such reported forecast, "forecasted refinancings median value" means the forecast for median value of mortgage originations for refinancings in California as reported by the Mortgage Bankers Association for the latest available 12–month period.

(r) "Historical median value" (HistoricalMedValue) means

(1) the sum of

(A) the amount

(i) historical existing home sales (HistExistSales);

(ii) multiplied by historical existing home median value (HistExistValue);

(B) the amount

(i) historical new home sales (HistNewSales);

(ii) multiplied by historical new home median value (HistNewValue); and

(C) the amount

(i) historical refinancings (HistRefis);

(ii) multiplied by historical refinancings median value (HistRefi Value);

(2) divided by the historical transactions (HistoricalTrans).

Stated as an equation:

$$HistMedValue = \frac{(HistExistSales * HistExistValue + HistNewSales * HistNewValue + HistRefis * HistRefiValue)}{HistoricalTrans}$$

(s) "Forecasted median value" (ForecastMedValue) means

(1) the sum of

(A) the amount

(i) forecasted existing home sales (FsctExistSales);

(ii) multiplied by forecasted existing home median value (FcstExistValue);

(B) the amount

(i) forecasted new home sales (FcstNewSales);

(ii) multiplied by forecasted new home median value (FcstNewValue); and

(C) the amount

(i) forecasted refinancings (FcstRefis);

(ii) multiplied by forecasted refinancings median value (FcstRefiValue);

(2) divided by the forecasted transactions (ForecastTrans).

Stated as an equation:

$$ForecastMedValue = \frac{(FcstExistSales * FcstExistValue + FcstNewSales * FcstNewValue + FcstRefis * FcstRefiValue)}{ForecastTrans}$$

(t) "Market value growth factor" (MarketGrowthFactor) means

(1) the quantity

(A) forecasted median value (ForecastMedValue);

(B) divided by historical median value (HistoricalMedValue);

(2) raised to the quantity

(A) n, the number of months between the midpoint of the historical period and the midpoint of the effective period,

(B) divided by 12.

Stated as an equation:

$$MarketGrowthFactor = \left(\frac{ForecastMedValue}{HistoricalMedValue}\right)^{\frac{n}{12}}$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.5. Advisory Organizations.

(a) The Commissioner shall designate two advisory organizations, as follows, with which to consult on the implementation of this article:

(1) The Commissioner shall designate one statistical agent to serve as an advisory organization. The statistical agent shall have at least five years of experience in data collection, data maintenance, data quality control, accounting, and related matters, and shall have among its members title insurers and underwritten title companies. The statistical agent shall be responsible for receiving data from or on behalf of the Commissioner and process the data in accordance with this article and with the directions of the Commissioner. The statistical agent shall be funded by its members in accordance with the rules of that organization, and in an amount determined by that organization.

(2) The Commissioner shall designate one statistical adviser to serve as an advisory organization. The statistical adviser shall have at least five years of experience in title insurance and in economic or actuarial analysis and shall have experience representing consumers in insurance matters. The statistical adviser shall be responsible for advising the Commissioner and the statistical agent on implementation of this article.

(b) The statistical agent and statistical adviser shall each be selected by separate competitive bidding in response to requests for proposals. In selecting the statistical adviser, the Commissioner may consider cost, qualifications, and a demonstrated understanding of the services required to implement this article.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.6. Findings.

Pursuant to Section 12401.3 of the Insurance Code, the Commissioner finds that a reasonable degree of competition does not exist in the following phases of the business of title insurance:

(a) title search, examination, and commitment;

(b) issuance and servicing of title insurance policies;

(c) escrow and closing; and

(d) other services.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.7. Public Hearing on Statistical Plan and Financial Data.

Not less frequently than annually, the Commissioner shall, prior to their publication, hold an informational hearing for the purpose of receiving and reviewing comments on the compilations, corrections, and calculations made and used pursuant to this article.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2355.8. Public Information.

(a) The following reports submitted pursuant to subarticle 2 of this article are public information and are subject to production pursuant to the Public Records Act, Government Code Section 6250 et seq.

TI02	California and Countrywide Balance Sheet
TI03	California and Countrywide Income Statement
TI04	Detailed Personnel Expense Report
TI06	Report of Work Charges/Premium Splits
TI07	Report of Amounts Paid To or Received From Other Licensees and Affiliates
TI08	Report of Other Services
TI09	Facilities Location Report
TI10	Report of Title Premium by Underwritten Title Company
TI11	Report of Escrow Discounts and Surcharges
TI12	Six–Year Report of Selected Data
TI13	Report of Unusual Charges
TI15	Loss Development Report
TI16	Report of Title Policy Forms, Endorsements, Discounts and Surcharges

UTC02	California and Countrywide Assets and Liabilities Report
UTC03	California and Countrywide Income Statement
UTC04	Detailed Personnel Expense Report
UTC06	Report of Work Charges/Premium Splits
UTC07	Report of Amounts Paid To or Received From Other Licensees and Affiliates
UTC08	Report of Other Services
UTC09	Facilities Location Report
UTC11	Report of Escrow Discounts and Surcharges
UTC12	Six–Year Report of Selected Data
UTC13	Report of Unusual Charges

(b) Any company submitting a report pursuant to subarticle 2 or this article that claims that any portion of the submission contains trade secret information shall so advise the Commissioner at time of submission and shall specify the trade secret information by report number and data element together with a statement why the information is a trade secret.

(c) Information claimed as a trade secret pursuant to the preceding subsection shall not be made public by the commissioner, pursuant to the California Public Records Act or otherwise, without first giving the company at least 30 days' written notice and an opportunity to object to the release and to seek a court order preventing release.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code; and Section 6253, Government Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

Subarticle 2. Statistical Plan and Annual Financial Data Reporting Requirements

§ 2356.1. California Title Insurance Statistical Plan and Annual Financial Data Reporting Requirements.

This subarticle contains the California Title Insurance Statistical Plan and Annual Financial Data Reporting Requirements.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New subarticle 2 (sections 2356.1–2356.9) and section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.2. Who Is Required to Report.

(a) All title insurance companies licensed to transact business in California shall report their experience in the business of title insurance in California pursuant to the instructions of the California Title Insurance Statistical Plan.

(b) Underwritten title companies and controlled escrow companies shall report their experience in the business of title insurance in California pursuant to the instructions of the Annual Financial Data Reporting Requirements. Title insurance companies and underwritten title companies are required to file separate financial data reports for controlled escrow companies which are controlled by the title insurance company or underwritten title company whose activity is not otherwise included in the title insurance company or underwritten title company submission.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.3. What to Report.

(a) Title insurance companies shall submit the following financial data reports pursuant to the California Title Insurance Statistical Plan:

TI01	Title and Escrow Transaction Report
TI02	California and Countrywide Balance Sheet
TI03	California and Countrywide Income Statement
TI04	Detailed Personnel Expense Report
TI05	Detailed Escrow Report
TI06	Report of Work Charges/Premium Splits
TI07	Report of Amounts Paid To or Received From Other Licensees and Affiliates
TI08	Report of Other Services
TI09	Facilities Location Report
TI10	Report of Title Premium by Underwritten Title Company
TI11	Report of Escrow Discounts and Surcharges
TI12	Six–Year Report of Selected Data
TI13	Report of Unusual Charges
TI14	Detailed Title Policy Report
TI15	Detailed Claim Report
TI16	Loss Development Report
TI17	Report of Title Policy Forms, Endorsements, Discounts and Surcharges

(b) Underwritten title companies shall submit the following financial data reports pursuant to the Annual Financial Data Reporting Requirements:

UTC01	Title and Escrow Transaction Report
UTC02	California and Countrywide Balance Sheet
UTC03	California and Countrywide Income Statement
UTC04	Detailed Personnel Expense Report
UTC05	Detailed Escrow Report
UTC06	Report of Work Charges/Premium Splits
UTC07	Report of Amounts Paid To or Received From Other Licensees and Affiliates
UTC08	Report of Other Services
UTC09	Facilities Location Report
UTC10	Report of Title Premium by Title Insurance Company

UTC11 Report of Escrow Discounts and Surcharges
UTC12 Six–Year Report of Selected Data
UTC13 Report of Unusual Charges

(c) For experience of controlled escrow companies that is not included in the submission of the title insurance company or underwritten title company which controls the controlled escrow company, the controlling title insurance company or underwritten title company shall, pursuant to the Annual Financial Data Reporting Requirements, submit the following financial data reports for each such controlled escrow company:

UTC01 Title and Escrow Transaction Report
UTC02 California and Countrywide Assets and Liabilities Report
UTC03 California and Countrywide Income Statement
UTC04 Detailed Personnel Expense Report
UTC05 Detailed Escrow Report
UTC06 Report of Work Charges/Premium Splits
UTC07 Report of Amounts Paid To or Received From Other Licensees and Affiliates
UTC08 Report of Other Services
UTC09 Facilities Location Report
UTC11 Report of Escrow Discounts and Surcharges
UTC12 Six–Year Report of Selected Data
UTC13 Report of Unusual Charges

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.4. When to Report.

(a) The initial annual submission of all experience reports required by this statistical plan shall cover experience from January 1, 2009 through December 31, 2009 and must be received by the Commissioner on or before April 30, 2010.

(b) Following the initial submission, all experience reports required by this statistical plan shall cover experience in a calendar year and shall be received by the Commissioner on or before April 30 following the experience year reported. For example, the second annual submission shall cover 2010 experience and be received by the Commissioner no later than April 30, 2011.

(c) In order to assist reporting companies and the statistical agent with compliance with reporting requirements, each company shall, on or before June 30, 2009, submit all experience reports for the period January 1, 2009, through March 31, 2009, with the following limitations and exceptions.

(1) Balance sheet reports shall state financial condition as of March 31, 2009. Affected reports are TI02, UTC02, and portions of TI12 and UTC12.

(2) All reports other than TI02, TI16, UTC02, and the balance sheet portions of TI12 and UTC12 shall contain experience for the period January 1, 2009 through March 31, 2009 only and shall include only current period reporting. Prior period reporting is not required for this initial submission.

(3) Report TI16 shall be reported in full detail as of December 31, 2008, meaning the most current reporting year is the full year 2008.

(d) Any underwritten title company or controlled escrow company having revenues less than $10 million in the preceding calendar year and having less than 10% common ownership or control by or of any other title insurer, underwritten title company, or controlled escrow company may, on or before October 1, apply for a one–year extension of its reporting requirements pursuant to this section for the following year. The Commissioner shall grant the application only if the applicant has shown by sworn testimony and documentary evidence each of the following:

(1) That the applicant is making a diligent effort to comply with this subarticle,

(2) That suitable data–processing products and services are not commercially available, and cannot reasonably be expected to be available, to enable the applicant economically to comply with this subarticle in the following year.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.5. How to Report.

(a) What Constitutes a Submission. Each submission consists of a transmittal form, a certification and data reports for a single title insurance company or single underwritten title company. Experience of controlled escrow companies not otherwise included in the reports of the controlling title insurance company or underwritten title company shall be included in separate reports and included in the submission of the controlling title insurance company or underwritten title company.

(b) Financial Data Reports Formats. All data reports shall be submitted in the record layout and format prescribed for each report in this Statistical Plan. The following reports must be submitted using the spreadsheet templates provided by the Commissioner at the California Department of Insurance web site.

TI02 California and Countrywide Balance Sheet
TI03 California and Countrywide Income Statement
TI04 Detailed Personnel Expense Report
TI12 Six–Year Report of Selected Data
TI15 Loss Development Report
UTC02 California and Countrywide Balance Sheet
UTC03 California and Countrywide Income Statement
UTC04 Detailed Personnel Expense Report
UTC12 Six–Year Report of Selected Data

(1) The remaining reports may be submitted in one of the following electronic formats:

(A) Spreadsheet compatible with Microsoft Excel;

(B) Database compatible with Microsoft Access; or

(C) Text File in Comma Delimited format, meaning field (column) entries are separated by commas and text entries are contained within quotation marks and records or rows are separated by a line break.

(2) Templates illustrating the required reporting format are provided by the Commissioner and available at the California Department of Insurance web site: www.insurance.ca.gov.

(c) Reporting No Experience. If the reporting company has no experience to report for a particular report, the reporting company need not submit an electronic file for such report but shall indicate no experience to report for any such report on the submission transmittal form.

(d) Transmittal Form. The transmittal form shall be submitted in electronic format using the spreadsheet template provided by the Commission at the California Department of Insurance web site. If a title insurance company or underwritten title company is submitting reports of a controlled escrow company which is controlled by the reporting title insurance company or underwritten title company but whose experience is not otherwise included in the reports of the controlling title insurance company or underwritten title company, a separate transmittal form must be submitted for the controlled escrow company reports.

The transmittal form shall contain the following information:

(1) company name;

(2) either

(A) NAIC company code for title insurance companies, or

(B) California UTC code for underwritten title companies, or

(C) a company–supplied unique code from Z001 through Z999 for a controlled escrow company whose experience is not included in the reports of the controlling title insurance company or underwritten title company.

(3) initial submission or resubmission;

(4) name and format of files submitted;

(5) number of records in each report submitted. An entry of zero for number of records indicates no experience to report for a specific report and, if the number of records is zero, no electronic file submission of the no–experience report is required; and

(6) control totals for selected data fields for selected reports.

(e) Certification. Each submission must be accompanied by a certification by an officer of the reporting company that the information in the submission is complete, accurate and in compliance with relevant California laws and regulations. The certification must be made with a form provided by the Commissioner and available on the California Department of Insurance web site, www.insurance.ca.gov, and such form will be in substantially the following form:

I, [Name of Officer of Company] of the [Name of Company], certifies (or declares) that I am the officer above designated by the title appearing after my name, of the above Company and am authorized by the Company to certify (or declare) and hereby do certify (or declare):

That I am the officer authorized to certify (or declare) to the accuracy of the attached or e-mailed submission (hereafter called the Submission).

That the Submission is a complete submission of the data required by California Code of Regulations, title 10, article 7.1, subarticle 2.

That the Submission complies with the requirements of California Code of Regulations, title 10, article 7.1, subarticle 2.

That the Submission represents a true and correct report of the data required by California Code of Regulations, title 10, article 7.1, subarticle 2.

That I understand Section 2015.5 of the Code of Civil Procedure provides that the above form of certification or declaration under the penalty of perjury is of like force and effect as verification under oath.

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at [Place] on [Date]

[Signature of Officer of Company]

The certification must be submitted in hard copy with original signature and as an electronic file in the Portable Document Format (pdf). If a title insurance company or underwritten title company is submitting reports of a controlled escrow company which is controlled by the reporting title insurance company or underwritten title company but whose experience is not otherwise included in the reports of the controlling title insurance company or underwritten title company, a separate certification must be submitted for the controlled escrow company reports.

(f) Method of Delivery. Each submission — whether an initial annual submission or resubmission — shall be delivered to the Commissioner by a method with delivery confirmation.

(g) Contents of Submission. Each submission shall include the required paper certification documents and a CD-ROM or DVD containing all the required electronic files, including all required data reports, transmittal form and electronic copy of the certification.

(h) File Naming Conventions.

(1) Initial Data Report Submission of a Title Insurance Company or Underwritten Title Company: Each data report shall be submitted as a separate electronic file and named using the following conventions:

AAAA_BBBBB_CCCCC.EEE

where

- AAAA is the experience year reported;
- _ is a single space;
- BBBBB is the report name;
- CCCCC is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- EEE is the file extension, which must be .txt for a Comma Delimited file.

Example: Report TI01 for 2010 experience from a title insurance company with an NAIC Code of 51111 submitted in a comma delimited format:

2010 TI01 51111.txt

(2) Resubmission of a Data Report of a Title Insurance Company or Underwritten Title Company: If a data report is being resubmitted, the file name shall be:

AAAA_BBBBB_CCCCC_RX.EEE

where

- AAAA is the experience year reported;
- _ is a single space;
- BBBBB is the report name;
- CCCCC is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- RX is the number of the submission, with R1 being the first resubmission, R2 being the second resubmission and so on;
- DDD is the file extension, which must be . txt for a Comma Delimited file.

Example: The first resubmission of the 2010 TI01 from a title insurance company with an NAIC Code of 51111 submitted in a comma delimited format:

2010 TI01 51111R1.txt

(3) Initial Data Report Submission of a Controlled Escrow Company Whose Experience Is Not Included in the Data Report of the Controlling Title Insurance Company or Underwritten Title Company: For a data report of the experience of a controlled escrow company whose experience is not otherwise included in the reports of the controlling title insurance company or underwritten title company, the file name shall be:

AAAA_BBBBB_ZZZZ_CCCCC.EEE

where

- AAAA is the experience year reported;
- _ is a single space;
- BBBBB is the report name;
- ZZZZ is a unique code assigned by the controlling title insurance company or underwritten title company to the controlled escrow company whose experience is being reported with codes starting with Z001 and continuing through Z999, as necessary;
- CCCCC is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- DDD is the file extension, which must be .txt for a Comma Delimited file.

Example: The initial submission of the 2010 UTC01 for a controlled escrow company controlled by an underwritten title company with the California UTC code of U1234 in spreadsheet format:

2010 UTC01 Z001 U1234.xls

(4) Resubmission of a Data Report of a Controlled Escrow Company Whose Experience Is Not Included in the Data Report of the Controlling Title Insurance Company or Underwritten Title Company: If a data report of the experience of a controlled escrow company whose experience is not otherwise included in the reports of the controlling title insurance company or underwritten title company is resubmitted, the file name shall be:

AAAA_BBBBB_ZZZZ_CCCCC_RX.DDD

where

- AAAA is the experience year reported;
- _ is a single space;
- BBBBB is the report name;
- ZZZZ is a unique code assigned by the controlling title insurance company or underwritten title company to the controlled escrow company whose experience is being reported with codes starting with Z001 and continuing through Z999, as necessary;
- CCCCC is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- RX is the number of the submission, with R1 being the first resubmission, R2 being the second resubmission and so on;
- DDD is the file extension, which must be .txt for a Comma Delimited file.

Example: The second resubmission of the 2010 UTC01 for a controlled escrow company controlled by an underwritten title company with the California UTC code of U1234 in spreadsheet format:

2010 UTC01 Z001 U1234 R2.xls

(5) Transmittal Form for Title Insurance Company or Underwritten Title Company Reports: After completing the transmittal form using the spreadsheet template provided by the Commissioner, the reporting company shall rename the spreadsheet file to:

YYYYDDMM_TRANS_BBBBB.EEE

- YYYYMMDD is the date of the submission with YYYY being the year, MM being the number of the month and DD being the day, together representing the date of the submission or resubmission.
- _ is a single space;
- TRANS is a unique name for the transmittal form in all capital letters;
- BBBBB is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- EEE is the file extension, which must be .xls for spreadsheet format.

Example: The transmittal form for a title insurance company with an NAIC Code of 51111 accompanying a submission made on April 30, 2010 would be named:

20100430 TRANS 51111.xls

(6) Transmittal Form for Data Reports of a Controlled Escrow Company Whose Experience Is Not Included in the Data Reports of the Controlling Title Insurance Company or Underwritten Title Company: After completing the transmittal form for the reports of the controlled escrow company using the spreadsheet template provided by the Commissioner, the reporting company shall rename the spreadsheet file to:

YYYYDDMM_TRANS_ZZZZ_BBBBB.EEE

where

- YYYYMMDD is the date of the submission with YYYY being the year, MM being the number of the month and DD being the day, together representing the date of the submission or resubmission;
- _ is a single space;
- TRANS is a unique name for the transmittal form in all capital letters;
- ZZZZ is a unique code assigned by the controlling title insurance company or underwritten title company to the controlled escrow company whose experience is being reported with codes starting with Z001 and continuing through Z999, as necessary;
- BBBBB is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- EEE is the file extension, which must be .xls for spreadsheet format.

Example: The transmittal form for a controlled escrow company controlled by a title insurance company with an NAIC Code of 51111 accompanying a submission made on April 30, 2010 would be named:

20100430 TRANS Z001 51111.xls

(7) Certification for Title Insurance Company or Underwritten Title Company Reports: Each submission must be accompanied by a certification using the form provided by the Commissioner in hard copy with original signature and as an electronic file in the Portable Document Format (pdf). The electronic copy of the certification shall be named:

YYYYDDMM_CERT_BBBBB.EEE

where

- YYYYMMDD is the date of the submission with YYYY being the two digits of the year, MM being the number of the month and DD being the day, together representing the date of the submission or resubmission;
- _ is a single space;
- CERT is a unique name for the certification form;
- BBBBB is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- EEE is the file extension, which must be .pdf for the Portable Document Format.

Example: The certification form for a title insurance company with an NAIC Code of 51111 accompanying a submission made on April 30, 2010 would be named:

20100430 CERT 51111.pdf

(8) Certification for Data Reports of a Controlled Escrow Company Whose Experience Is Not Included in the Data Reports of the Controlling Title Insurance Company or Underwritten Title Company: Each submission must be accompanied by a certification using the form provided by the Commissioner in hard copy with original signature and as an electronic file in the Portable Document Format (pdf). The electronic copy of the certification shall be named:

YYYYDDMM_CERT_ZZZZ_BBBBB.EEE

where

- YYYYMMDD is the date of the submission with YYYY being the two digits of the year, MM being the number of the month and DD being the day, together representing the date of the submission or resubmission;
- _ is a single space;
- CERT is a unique name for the certification form;
- ZZZZ is a unique code assigned by the controlling title insurance company or underwritten title company to the controlled escrow company whose experience is being reported with codes starting with Z001 and continuing through Z999, as necessary;
- BBBBB is the California UTC Code for Underwritten Title Company Reports or the NAIC Company Code for Title Insurance Company Reports;
- EEE is the file extension, which must be .pdf for the Portable Document Format.

Example: The certification form for a title insurance company with an NAIC Code of 51111 accompanying a submission made on April 30, 2010 would be named:

20100430 CERT Z001 51111.pdf

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code; and Section 2015.5, Code of Civil Procedure.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.6. Where to Submit.

Each reporting company shall submit its experience reports, transmittal form and certification to the Commissioner of Insurance at the following address:

RATE SPECIALIST BUREAU
ATTN: TITLE STATISTICAL PLAN SUBMISSION
300 SOUTH SPRING STREET, 14TH FLOOR
LOS ANGELES, CA 90013

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.7. Data Quality Acceptance Standards.

(a) Upon receipt of submitted data, the Commissioner will conduct a basic edit check of reported data. If the information on the transmittal form does not agree with the data tables or if greater than 1% of the records contain invalid formats, invalid codes and illogical entries, the Commissioner will reject the data submission and return it to the reporting company for correction and resubmission.

(b) In addition to the basic edit checks, the Commissioner will employ other means for verifying the accuracy of reported data, including audits

of the accuracy of data submissions with particular attention to the reporting company's accurate categorization of revenues, expenses, assets and liabilities. The Commissioner may reject faulty data and require resubmission of corrected data at any time up to five years after the initial required submission date of the report.

(c) Reporting companies shall respond within ten business days to any inquiry from the Commissioner regarding a data submission, including an inquiry that requires a resubmission of data reports, unless the Commissioner provides specific approval for a longer time period for a response.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.8. Title Insurer Statistical Plan Reports.

(a) TI01 Title and Escrow Transaction Report. Each title insurance company shall submit this report of title, escrow and other services transactions by the title insurance company during the reporting period. Include transactions that were opened in previous years and which were closed or cancelled during the reporting period. Include transactions that were opened during the reporting whether or not the transactions were closed, cancelled or remained open at the end of the reporting period. Each title insurance company shall submit a report UTC01 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI01 of the title insurance company.

(1) This report can be visualized as a table where each row is a separate record corresponding to a separate transaction and each column is a separate data field. For this report, a transaction is the set of activities associated with a single property transaction. For example — for this report — a transaction might consist of title, escrow and other service activities if all those activities were performed for the same property transaction. Or the transaction might consist of only title activity if, for example, a preliminary report was the only activity performed for the particular property transaction. A transaction may consist of any combination of title, escrow and other services activities to the extent one or more of the activities were performed for a single property transaction. The data fields described for this report, below, can be visualized as the columns in a table.

(2) Any direct business — business conducted by the title insurance company without the involvement of an underwritten title company — shall be included in this report. The reporting company shall include only that experience that would not otherwise be reported in any UTC01 report, which is the Title and Escrow Transaction Report of underwritten title companies, with the exception of activity involving work charges/premium splits with another underwritten title company or title insurance company. For example, the transaction activity associated with a title policy issued with the involvement of an underwritten title company will be reported in that underwritten title company's UTC01 report and shall not be reported as a transaction by the title insurance company in TI01. However, a transaction that involves a work charge/premium split — described in the instructions for column TI01.F — shall be reported by both organizations involved in that transaction reflecting their respective activities in the transaction. For example, if a title insurer and an underwritten title company employed a work charge/premium split for a title policy on a particular real estate transaction, both organizations shall report their respective activity on that transaction in their respective Title and Escrow Transaction Reports.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI01.A	Name of Reporting Entity	Report the name of the title insurance company. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI01 report of the title insurance company. The Title and Escrow Transaction Report for such a controlled escrow company reports shall be completed using the UTC01 report format.
TI01.B	Reporting Year	Report the calendar year experience period as a four–digit number. Report experience during the reporting period.
TI01.C	Internal Transaction #	Report the internal transaction number or code used to identify this transaction from other transactions. If no such internal transaction numbers are used, create a unique number or code for each transaction.
TI01.D	Type of Title and Escrow Transaction	Report one of the following codes. Title refers to a preliminary report, title policy, title guaranty or other activity regarding the assurance of title. Full escrow refers to the complete set of escrow activities associated with a typical residential transaction including, at a minimum: • Serving as the liaison to all parties in the transaction; • Preparing escrow instructions; • Requesting a preliminary title search or title commitment to determine the present condition of title to the property; • Complying with the lender's requirements as specified in the escrow agreement; • Receiving purchase funds from the buyer; • Preparing or securing the deed or other documents related to escrow; • Prorating taxes, interest, insurance and rents according to instructions; • Securing releases of all contingencies or other conditions required; • Recording deeds and any other documents as instructed; • Closing escrow when all instructions from buyer and seller have been carried out; • Disbursing authorized funds; and • Preparing final statement "Subescrow" refers to funds transfer for lenders in those situations where an entity other than the reporting company is performing other escrow activities. Subescrow typically occurs in Southern California when escrow is performed by independent escrow companies. 1. Title and Full Escrow 2. Title and Subescrow 3. Title Only 4. Full Escrow Only 5. Subescrow Only 6. None of the Above
TI01.E	Other Services	Report one of the following codes. Other services refer to services or products other than a preliminary report, title policy, full escrow or subescrow. 1. Other Services Provided 2. Other Services Not Provided

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI01.F	Work Charge/ Premium Split	Pursuant to Insurance Code § 12412, a title insurance company may divide fees or charges, for work and services actually performed, between title insurance companies or between title insurance companies and underwritten title companies. A work charge or premium split refers to a payment from the reporting company to another title insurance company or to a title insurer or a payment to the reporting company from another title insurance company or underwritten title company. Some companies refer to work charges as premium splits because the company collecting the title premium or escrow fee pays a portion of the premium or escrow fee to another company for services provided in connection with the title or escrow transaction. Work charges/ premium splits refer only to payments between title insurance companies, between underwritten title companies or between underwritten title companies and title insurers. Report one of the following codes: 1. Paid a work charge to another title insurance company, underwritten title company or controlled escrow company 2. Received a work charge from another title insurance company, underwritten title company or controlled escrow company 3. Paid a work charge and received work charge from another title insurance company, underwritten title company or controlled escrow company 4. No work charge paid or received
TI01.G	Type of Real Estate Transaction	Report one of the following codes: 1. Residential Sale — New Home 2. Residential Sale — Resale of Existing Home 3. Residential Sale — Land Only 4. Residential Refinance 5. Residential Home Equity 6. Commercial or Industrial Sale 7. Commercial or Industrial Refinance 8. Other
TI01.H	Street Address of Property	Report the street address of the property that is the subject of the transaction.
TI01.I	ZIP Code of Property	Report the 5-Digit ZIP Code location of the property that is the subject of the transaction as XXXXX.
TI01.J	County of Property	Report the county location of the property that is the subject of the transaction.
TI01.K	Source of Order	Report the name of the source of the title and/or escrow order. The source of the title order is the entity referring the business to the title insurance company. The source of the title order may not be the reporting company itself. If the source of business is the escrow department of the reporting company, report the escrow department's source of business. Report the complete name of any real estate agent, real estate agency, lender, homebuilder or other business source. Report the business name of the source, if one exists.
TI01.L	Affiliated Source	Report 1 if the source of business is affiliated with the reporting company or 0 if the source of business is not affiliated with the reporting company.
TI01.M	Date Order Opened	Report the date the order was opened in YYYYMMDD format.
TI01.N	Date Order Cancelled	If the order was cancelled, report the date cancelled in YYYYMMDD format.
TI01.O	Date Order Closed	If the order was closed, report the date closed in YYYYMMDD format
TI01.P	Type of Title Transaction	Report one of the following codes: 1. Concurrent Issue of Single Owner's Policy and Single Lender's Policy 2. Concurrent Issue of Multiple Owner's Policies and Single Lender's Policy 3. Concurrent Issue of Single Owner's Policy and Multiple Lender's Policies 4. Concurrent Issue of Multiple Owner's Policies and Multiple Lenders' Policies 5. Single Owner's Policy Only 6. Single Lender's Policy Only 7. Multiple Owners' Policies Only 8. Multiple Lender's Policies Only 9. Title Guaranty 10. Other Title Transaction
TI01.Q	Preliminary Report Delivered	Report one of the following codes: 1. Preliminary report delivered with no charge 2. Preliminary report delivered with a charge 3. Preliminary report prepared but not delivered 4. No preliminary report prepared
TI01.R	Preliminary Report Charge	If a separate charge was made for the preliminary report, report the amount received for the preliminary report to the nearest dollar without commas, periods or dollar signs.
TI01.S	Title Premium Owner's Policy	If an owner's policy was issued, report the premium charge for the policy to the nearest dollar without commas, periods or dollar signs. If multiple owners' policies were issued, report the total premium charge for all owners' policies.
TI01.T	Title Premium Lender's Policy	If a lender's policy was issued, report the premium charge for the policy to the nearest dollar without commas, periods or dollar signs. If multiple lenders' policies were issued, report the total premium charge for all lenders' policies.
TI01.U	Escrow Charge	If a charge was made for setting up, conducting or canceling full escrow, report the amount of the charge to the nearest dollar without commas, periods or dollar signs.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI01.V	Subescrow Charge	If a charge was made for setting up, conducting or canceling subescrow, report the amount of the charge to the nearest dollar without commas, periods or dollar signs.
TI01.W	Other Services Charges	If a charge was made for other services, report the total amount of the charges to the nearest dollar without commas, periods or dollar signs.
TI01.X	Title Search/Examination Location	Report the code from TI09 for the name and location of the facility where the title search and examination was conducted. This data field must have an entry if the entry in TI01.0D is 1, 2 or 3.
TI01.Y	Title Policy Issuance Location	Report the code from TI09 for the name and location of the facility where the title policy was produced and issued from. This data field must have an entry if there is an entry in TI01.S or TI01T.
TI01.Z	Escrow Office	Report the code from TI09 for the name and location of the facility where the escrow was carried out. This data field must have an entry if the entry in TI01.D is 1, 2, 4 or 5.
TI01.AA	Independent Escrow Company	If the transaction involved escrow services performed by an entity other than the reporting company, report the name of that entity. If the transaction did not involve escrow services provided by an entity other than the reporting company, leave blank.
TI01.AB	Independent Escrow Company Affiliation	If there is an entry in TI01.AA, report 1 if the entity is affiliated with the reporting company. Refer to Insurance Code Section 1215(a) for the definition of "affiliate" and "affiliated." If there is no entry in TI01.AA, leave blank.

(b) TI02 California and Countrywide Balance Sheet. Report TI02 is areport of assets and liabilities for title insurance companies on a consolidated GenerallyAccepted Accounting Principles (GAAP) basis. Preparation of Report TI02 requires consolidation of countrywide financial results of subsidiaries, conversion of countrywide consolidated financial results to a GAAP basis, allocation of countrywide financial results to individual states and summarization of individual states' financial results.

(1) A single Report TI02 shall be submitted for a title insurance company and any of its subsidiaries which are engaged in the business of title insurance, including:

- title insurance companies;
- underwritten title companies; and
- controlled escrow companies.

(2) A title insurance company licensed in California that is a subsidiary of another title insurance company or an underwritten title company licensed in California shall not submit Report TI02, but have its experience included in the report of the parent. There shall be only one submission for a parent title insurance company and all its subsidiaries engaged in the business of title insurance. Any title insurance company which is not submitting a Report TI02 because that company's experience has been consolidated into a parent company's submission shall indicate on its (the subsidiary's) individual submission transmittal form the name of the parent company which has submitted a Report TI02 or Report UTC02 which includes the experience of the subsidiary reporting company.

(3) Two or more title insurance companies — which are not subsidiaries of one another but are affiliated with one another because they are all subsidiaries of a parent holding company which is not a title insurance company, underwritten title company or controlled escrow company — must each submit a consolidated Report TI02 for the experience of the reporting company and any subsidiaries that are title insurance companies, underwritten title companies or controlled escrow companies.

(4) Report TI02 must be submitted using the spreadsheet template provided by the Commissioner on the Department of Insurance web site: www. insurance. ca.gov.

(5) Report TI02 includes two sections — assets/liabilities and adjustments. In the adjustments section, reporting companies shall report the consolidation and GAAP conversion adjustments made to individual statutory accounting reports for the business entities engaged in the business of title insurance in California.

(6) For most asset and liability items, the reporting company may choose the allocation method to assign the portion of those countrywide asset or liability amounts not identifiable with a specific state to California that best reflects amount of the asset or liability used to support the business of title insurance in California. The allocation of the following liability items is prescribed:

(A) Incurred But Not Reported Title Reserves: Allocate to California by the ratio of the sum of California–specific incurred title losses and California–specific title case loss reserves at the end of the reporting year to the sum of countrywide incurred title losses and countrywide title case loss reserves at the end of the reporting year.

(B) GAAP Net Worth: Allocate to California by the ratio of the sum of California reserves and California total revenue at the end of the reporting year to the sum of countrywide reserves plus total revenue at the end of the reporting year. Reserves are the sum of title case loss reserves, title incurred but not reported reserves and escrow loss reserves. Total revenue is the sum of gross title premium, escrow fees, subescrow fees and other services charges which are Lines TI03. 01, TI03. 04, TI03. 05 and TI03. 08, respectively, of Report TI03.

(7) Report TI02 requests experience for the current reporting year and the prior reporting year. For example, the 2009 TI03 report, submitted by April 30, 2010, contains assets and liabilities at year–end 2009 (the current reporting year) and at year–end 2008 (the prior reporting year).

(8) Reporting companies shall maintain any worksheets used in preparing Report TI02 for the six most recent reporting years.

(9) Data Fields for Section 1: Assets and Liabilities

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI02.A	Name of Reporting Entity	Report the name of the reporting company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report TI02.
TI02.B	Line #	Report the line number from the table in section 2356.8(b)(10) to indicate the asset or liability being adjusted or consolidated.
TI02.C	Line Description	Report the line description corresponding to the line number in TI02.C.
TI02.D	California Current Year Total	Report the sum of columns TI02.I and TI02.P for this line. This is a calculated amount in the spreadsheet template.
TI02.E	California Prior Year Total	Report the sum of columns TI02.K and TI02.S for this line. This is a calculated amount in the spreadsheet template.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI02.F	Elsewhere Current Year Total	Report the sum of TI02.H less TI02.D. This is a calculated amount in the spreadsheet template.
TI02.G	Elsewhere Prior Year Total	Report the sum of TI02.J less TI02.E. This is a calculated amount in the spreadsheet template.
TI02.H	Countrywide Consolidated Current Year Total	Report the consolidated GAAP–basis countrywide total for the current year for the asset or liability item in TI02.D. This amount comes from the consolidation worksheets.
TI02.I	Countrywide Consolidated Prior Year Total	Report the consolidated GAAP–basis countrywide total for the prior year for the asset or liability item in TI02.D. This amount comes from the consolidation worksheets.
TI02.J	California Identifiable Current Year	Report the amount of the asset or liability item in TI02.D that is identifiable with California–only business for the current year. Report only the amounts for items exclusively associated with California–only business. The current year is the most recent experience period. This amount comes from the allocation worksheets.
TI02.K	California Identifiable Prior Year	Report the amount of the asset or liability item in TI02.D that is identifiable with California–only business for the prior year. Report only the amounts for items exclusively associated with California–only business. The prior year is the most recent experience period prior to the current year. This amount comes from the allocation worksheets.
TI02.L	Elsewhere Identifiable Current Year	Report the amount of the asset or liability item in TI02.D that is identifiable with individual states other than California for the current year. Report only those amounts for items exclusively associated with individual states other than California. This amount comes from the allocation worksheets.
TI02.M	Elsewhere Identifiable Prior Year	Report the amount of the asset or liability item in TI02.D that is identifiable with individual states other than California for the prior. Report only those amounts for items exclusively associated with individual states other than California. The prior year is the most recent experience period prior to the current year. This amount comes from the allocation worksheets.
TI02.N	Countrywide Non–Identifiable Current Year	Report the amount TI02.H less the sum of TI02.J and TI02.L. This is a calculated amount in the spreadsheet template.
TI02.O	Basis for Allocation of Current Year	Non–IdentifiableReport the basis for determining the share of the amount reported in TI02.N associated with California business. Stated differently, report the method of allocating a portion of the amount in TI02.N to California business. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
TI02.P	California Allocation of Countrywide Non–Identifiable Current Year	Report the amount of item TI02.N allocated to California business using the method described in TI02.O for the current year.
TI02.Q	Countrywide Non–Identifiable Prior Year	Report the amount TI02.I less the sum of TI02.K and TI02.M. This is a calculated amount in the spreadsheet template.
TI02.R	Basis for Allocation of Prior Year Non–Identifiable	Report the basis for determining the share of the amount reported in TI02.Q associated with California business for the prior year. Stated differently, report the method of allocating a portion of the amount in TI02.Q to California business for the prior year. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
TI02.S	California Allocation of Countrywide Non–Identifiable Prior Year	Report the amount of item TI02.Q allocated to California business using the method described in TI02.R for the prior year.

(10) Data Rows for Section 1: Assets and Liabilities

The report of assets and liabilities shall be prepared according to Generally Accepted Accounting Principles (GAAP).

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI02.01	Assets: Cash and Cash Equivalents	Report consolidated and allocated GAAP amounts.
TI02.02	Assets: Accounts Receivable Net of Allowance for Doubtful Accounts	Report consolidated and allocated GAAP amounts.
TI02.03	Assets: Notes/Loans Receivable	Report consolidated and allocated GAAP amounts.
TI02.04	Assets: Prepaid Expenses	Report consolidated and allocated GAAP amounts.
TI02.05	Assets: Deferred Income Taxes	Report consolidated and allocated GAAP amounts.
TI02.06	Assets: Investments	Report consolidated and allocated GAAP amounts.
TI02.07	Assets: Property and Equipment Net of Depreciation	Report consolidated and allocated GAAP amounts.
TI02.08	Assets: Escrow Statutory Deposits with Insurance Commissioner	Report consolidated and allocated GAAP amounts.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI02.09	Assets: Goodwill/Costs in Excess of Assets Acquired	Report consolidated and allocated GAAP amounts.
TI02.10	Assets: Title Plant	Report consolidated and allocated GAAP amounts.
TI02.11	Assets: Aggregate Write–Ins for Assets	This is a calculated amount and no entry is required in the spreadsheet template. This entry is carried from the list of write–ins for assets.
TI02.12	Assets: Total	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines TI02.01 through TI02.11.
TI02.13	Liabilities: Accounts Payable and Accrued Expenses	Report consolidated and allocated GAAP amounts.
TI02.14	Liabilities: Title Premium	Report consolidated and allocated GAAP amounts.
TI02.15	Liabilities: Notes/Loans Payable	Report consolidated and allocated GAAP amounts.
TI02.16	Liabilities: Leases Payable	Report consolidated and allocated GAAP amounts.
TI02.17	Liabilities: Accrued Personnel Costs — Salary, Bonus and Vacation Payable	Report consolidated and allocated GAAP amounts.
TI02.18	Liabilities: Pensions and Retirement Plans	Report consolidated and allocated GAAP amounts.
TI02.19	Liabilities: Title Case Loss Reserves	Report consolidated and allocated GAAP amounts.
TI02.20	Liabilities: Title Incurred But Not Reported Loss Reserves	Report consolidated and allocated GAAP amounts. Allocate to California by the ratio of the sum of California–specific incurred title losses and California–specific title case loss reserves at the end of the reporting year to the sum of countrywide incurred title losses and countrywide title case loss reserves at the end of the reporting year.
TI02.21	Liabilities: Escrow Claim Reserves	Report consolidated and allocated GAAP amounts.
TI02.22	Liabilities: Total Reserves	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines TI02.19 through TI02.21.
TI02.23	Liabilities: Aggregate Write–Ins for Liabilities	This is a calculated amount and no entry is required in the spreadsheet template. This entry is carried from the list of write–ins for liabilities.
TI02.24	Liabilities: Total	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines TI02.13 through TI02.21 and TI02.23.
TI02.25	Equity: Stock	Report only consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
TI02.26	Equity: Additional Paid–In Capital	Report only consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
TI02.27	Equity: Retained Earnings	Report only consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
TI02.28	Equity: Aggregate Write–Ins for Equity	Report only consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
TI02.29	Equity: Total	This is a calculated amount for countrywide amount columns and no entry is required in the spreadsheet template. This entry is the sum of lines TI02.25 through TI02.28. For California amount columns, allocate to California by the ratio of the sum of California reserves and California total revenue at the end of the reporting year to the sum of countrywide reserves plus total revenue at the end of the reporting year.
TI02.30	Liabilities and Equity: Total	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines TI02.24 and TI02.29.

(11) Data Fields for Section 2: Adjustments for Consolidation and GAAP Conversion

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI02.AA	Name of Reporting Entity	Report the name of the insurer group or holding company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report TI02
TI02.AB	Line #	Report the line number from the table in section 2356.8.(b)(10) to indicate the asset or liability item being adjusted or consolidated.
TI02.AC	Line Description	Report one of the following codes: 1. Consolidation Adjustment 2. GAAP Conversion Adjustment

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI02.AD	Reporting Period	Report one of the following codes: 1. Current Year 2. Prior Year
TI02.AE	Parent Company	If entry in TI02.AC is 1 (consolidation adjustment), report the complete name of the parent company.
TI02.AF	Subsidiary Company	If entry in TI02.AC is 1 (consolidation adjustment), report the complete name of the subsidiary company.
TI02.AG	Amount of Adjustment	Report the amount of the consolidation or GAAP conversion adjustment.
TI02.AH	Description of Adjustment	Provide a description of the consolidation or GAAP conversion adjustment in sufficient detail to enable a person familiar with SAP and GAAP accounting to understand the exact adjustment made. The spreadsheet template can accept detailed explanations.

(c) TI03 California and Countrywide Income Statement. Report TI03 is a report of income and expenses for title insurance companies on a consolidated Generally Accepted Accounting Principles (GAAP) basis. Preparation of Report TI03 requires consolidation of countrywide financial results of subsidiaries, conversion of countrywide consolidated financial results to a GAAP basis, allocation of countrywide financial results to individual states and summarization of individual states' financial results.

(1) A single Report TI03 shall be submitted for a title insurance company and any of its subsidiaries which are engaged in the business of title insurance, including:

- title insurance companies;
- underwritten title companies; and
- controlled escrow companies.

(2) A title insurance company licensed in California that is a subsidiary of another title insurance company or an underwritten title company licensed in California shall not submit Report TI03, but have its experience included in the report of the parent. Stated differently, there shall be only one submission for a parent title insurance company and all its subsidiaries engaged in the business of title insurance. Any title insurance company which is not submitting a Report TI03 because that company's experience has been consolidated into a parent company's submission shall simply indicate on its (the subsidiary's) individual submission transmittal form the name of the parent company which has submitted a Report TI03 which includes the experience of the subsidiary reporting company.

(3) Two or more title insurance companies — which are not subsidiaries of one another but are affiliated with one another because they are all subsidiaries of a parent holding company which is not a title insurance company, underwritten title company or controlled escrow company — must each submit a consolidated Report TI03 for the experience of the reporting company and any subsidiary title insurance companies, underwritten title companies or controlled escrow companies.

(4) Report TI03 must be submitted using the spreadsheet template provided by the Commissioner on the Department of Insurance web site: www. insurance. ca.gov.

(5) Report TI03 includes two sections — income/expenses and adjustments. In the adjustments section, reporting companies shall report the consolidation and GAAP conversion adjustments made to individual statutory accounting reports for the business entities engaged in the business of title insurance in California.

(6) Report TI03 requests experience for the current reporting year and the prior reporting year. For example, the 2009 TI03 report, submitted by April 30, 2010, contains revenue and expenses for the calendar year 2009 (the current reporting year) and for the calendar year 2008 (the prior reporting year).

(7) For most expense items, the reporting company may choose the allocation method to assign the portion of those countrywide expense amounts that are not identifiable with a specific state to California that best reflects amount of the expense used to support the business of title insurance in California. The allocation of the following expense items is prescribed:

(A) Unallocated Title Loss Adjustment Expense: Allocate to California by the ratio of the sum of California–specific incurred title losses and incurred title allocated loss adjustment expense to the sum of countrywide incurred title losses and incurred title allocated loss adjustment expenses. Allocated loss adjustment expenses are claim settlement expenses that are solely associated with a specific title claim. Unallocated loss adjustment expenses are other claim settlement expenses which are not solely associated with a specific title claim.

(B) Unallocated Escrow Loss Adjustment Expense: Allocate to California by the ratio of the sum of California–specific incurred escrow losses and incurred escrow allocated loss adjustment expense to the sum of countrywide incurred escrow losses and incurred escrow allocated loss adjustment expenses. Allocated loss adjustment expenses are claim settlement expenses that are solely associated with a specific escrow claim. Unallocated loss adjustment expenses are other claim settlement expenses which are not solely associated with a specific escrow claim.

(8) Reporting companies shall maintain any worksheets used in preparing Report TI03 for the five most recent reporting years.

(9) Report TI03 includes some expense categories that may be pass–through items on a real estate transaction closing statement, where pass–through means that the amount for a particular item by a party to the transaction is the exact amount received by a service provider other than the reporting company. Reporting companies shall not include pass–through items in reported income or expenses.

(10) TI03 Data Fields for Section 1: Income and Expenses

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI03.A	Name of Reporting Entity	Report the name of the title insurance company. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI03 report of the title insurance company. The California and Countrywide Balance Sheet for such a controlled escrow company reports shall be completed using the UTC0 3report format.
TI03.B	Line #	Report the line number from the table in section 2356.8(c)(11) to indicate the income or expense item being adjusted or consolidated.
TI03.C	Line Description	Report the line description, corresponding to the line number in TI03.C.
TI03.D	California Current Year Total	Report the sum of columns TI03.I and TI03.P for this line. This is a calculated amount in the spreadsheet template.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI03.E	California Prior Year Total	Report the sum of columns TI03.K and TI03.S for this line. This is a calculated amount in the spreadsheet template.
TI03.F	Elsewhere Current Year Total	Report the sum of TI03.H less TI03.D. This is a calculated amount in the spreadsheet template.
TI03.G	Elsewhere Prior Year Total	Report the sum of TI03.J less TI03.E. This is a calculated amount in the spreadsheet template.
TI03.H	Countrywide Current Year Total	Report the consolidated GAAP–basis countrywide total for the current year for the income or expense item in TI03.D.
TI03.I	Countrywide Prior Year Total	Report the consolidated GAAP–basis countrywide total for the prior year for the income or expense item in TI03.D.
TI03.J	California Identifiable Current Year	Report the amount of the income or expense item in TI03.D that is identifiable with California–only business for the current year. Report only the amounts for items exclusively associated with California–only business. The current year is the most recent experience period.
TI03.K	California Identifiable Prior Year	Report the amount of the income or expense item in TI03.D that is identifiable with California–only business for the prior year. Report only the amounts for items exclusively associated with California–only business. The prior year is the most recent experience period prior to the current year.
TI03.L	Elsewhere Identifiable Current Year	Report the amount of the income or expense item in TI03.D that is identifiable with individual states other than California for the current year. Report only those amounts for items exclusively associated with individual states other than California.
TI03.M	Elsewhere Identifiable Prior Year	Report the amount of the income or expense item in TI03.D that is identifiable with individual states other than California for the prior. Report only those amounts for items exclusively associated with individual states other than California. The prior year is the most recent experience period prior to the current year.
TI03.N	Countrywide Non–Identifiable Current Year	Report the amount TI03.H less the sum of TI03.J and TI03.L. This is a calculated amount in the spreadsheet template.
TI03.O	Basis for Allocation of Current Year Non–Identifiable	Report the basis for determining the share of the amount reported in TI03.N associated with California business. Stated differently, report the method of allocating a portion of the amount in TI03.N to California business. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
TI03.P	California Allocation of Countrywide Non–Identifiable Current Year	Report the amount of item TI03.N allocated to California business using the method described in TI03.O for the current year.
TI03.Q	Countrywide Non–Identifiable Prior Year	Report the amount TI03.I less the sum of TI03.K and TI03.M. This is a calculated amount in the spreadsheet template.
TI03.R	Basis for Allocation of Prior Year Non–Identifiable	Report the basis for determining the share of the amount reported in TI03.Q associated with California business for the prior year. Stated differently, report the method of allocating a portion of the amount in TI03.Q to California business for the prior year. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
TI03.S	California Allocation of Countrywide Non–Identifiable Prior Year	Report the amount of item TI02.Q allocated to California business using the method described in TI02.R for the prior year.

(11) Data Rows for Section 1: Income and Expenses

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI03.01	Gross Written Title Premium	Report total gross title premium before remittances to underwritten title companies during the reporting period. Report direct business, meaning before adjustments for reinsurance. Include direct business, meaning business performed by the reporting company without the use of an underwritten title company. Report the entire gross premium and do not deduct any amounts incurred for work charges/premium splits or add any amounts received for work charges/premium splits. Report premium only for transaction in which the reporting company was the initial recipient of funds from the ultimate consumer. If a work charge/premium split is involved, only one reporting company shall report the gross title premium.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI03.02	Work Charges Incurred for Title	Pursuant to Insurance Code § 12412, an underwritten title company may divide fees or charges, for work and services actually performed, between underwritten title companies or between title insurance companies and underwritten title companies. A work charge or *premium* split refers to a payment from the reporting company to another underwritten title company or to a title insurer or a payment to the reporting company from another underwritten title company or a title insurer for work performed on title or escrow. Some companies refer to work charges as premium splits because the company collecting the title premium or escrow fee pays a portion of the premium or escrow fee to another company for services provided in connection with the title or escrow transaction. Work charges/premium splits refer only to payments between underwritten title companies or between underwritten title companies and title insurers. See the instructions for report TI05 for additional explanation of work charges/*premium splits*. In Line TI03.02, report only work charges incurred for title-related work during the reporting period.
TI03.03	Work Charges Received for Title	In Line TI03.03, report only work charges received for title-related work during the reporting period. See the instructions for Line TI03.02 for an explanation of work charges/premium splits.
TI03.04	Escrow Fees	Report total fees for full escrow during the reporting period. Report sub-escrow in line TI03.05. Report other service charges for escrow-related activity in line TI03.08. Report the entire escrow fee and do not deduct any amounts incurred for work charges/fee splits or add any amounts received for work charges/fee splits. Report escrow fees only for transactions in which the reporting company was the initial recipient of funds from the ultimate consumer. If a work charge/fee split is involved, only one reporting company shall report the escrow fee.
TI03.05	Subescrow Fees	Subescrow refers to funds transfer for lenders in those situations where an entity other than the reporting company is performing other escrow activities. Subescrow typically occurs in Southern California when escrow is performed by independent escrow companies. Report only those revenues in Line TI03.05 associated with a separate and identifiable charge for subescrow activities during the reporting period, whether those activities are called subescrow or something else, such as title payoff.
TI03.06	Work Charges Incurred for Escrow	In Line TI03.06, report only work charges incurred for escrow-related work during the reporting period. See the instructions for Line TI03.02 for an explanation of work charges/premium splits.
TI03.07	Work Charges Received for Escrow	In Line TI03.07, report only work charges received for escrow-related work during the reporting period. See the instructions for Line TI03.02 for an explanation of work charges/premium splits.
TI03.08	Other Service Charges	Report the amount of revenue from other service charges other than subescrow during the reporting period. Report subescrow on Line TI03.05
TI03.09	Revenue from Other Licensees	Report the amount of any revenue received from other licensees for services provided to those licensees, other than amounts received for work charges. Licensees are title insurance companies, underwritten title companies and controlled escrow companies licensed to conduct the business of title insurance in California. Include, for example, revenue received for title plant subscription fees, title search packages or production services. Report revenue from work charges in TI03.03 and TI03.07.
TI03.10	Aggregate Write-Ins for Other Operating Revenues	This amount is carried from the detailed write-in table below the income statement. Report any other types and amounts of operating revenue not included in lines TI03.01 through TI03.09 during the reporting period.
TI03.11	Total Operating Revenues	This amount is calculated and no entry is required in the spreadsheet template. This entry is the sum of Lines TI03.01 through TI03.10 during the reporting period.
TI03.12	Title Premium Retained by or Remitted to Underwritten Title Companies.	Report the amount of title premium from line TI03.01 that was retained by or remitted to underwritten title companies pursuant to underwriting agreements during the reporting period.
TI03.13	Personnel: Salaries	Report the amount of salaries for employees during the reporting period. This amount is carried from Table TI04 for the appropriate reporting period.
TI03.14	Personnel: Commission	Report the amount of commissions for employees during the reporting period. This amount is carried from Table TI04 for the appropriate reporting period.
TI03.15	Personnel: Bonus	Report the amount of bonuses for employees during the reporting period. This amount is carried from Table TI04 for the appropriate reporting period.
TI03.16	Personnel: Payroll Taxes	Report the amount of payroll taxes for employees during the reporting period. This amount is carried from Table TI04 for the appropriate reporting period.
TI03.17	Personnel: Employee Benefits	Report the amount of employee benefits for employees during the reporting period. Benefits include pension contributions, health insurance, life insurance, workers' compensation insurance, food for employees, gatherings and entertainment for employees and employee training. Report payroll taxes in Line TI03.16. Report expense allowances and reimbursements for sales personnel in TI03.57. This amount is carried from Table TI04 for the appropriate reporting period.
TI03.18	Personnel: Temporary Agency Expenses	Report the amount for temporary agencies for personnel during the reporting period. This amount is carried from Table TI04 for the appropriate reporting period.
TI03.19	Personnel: Contract Workers/Consultants	Report the amount for contract workers and consultants during the reporting period. Do not include amounts for legal or accounting services. Report these amounts in lines TI03.60 and TI03.58, respectively. This amount is carried from Table TI04 for the appropriate reporting period.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI03.20	Personnel: Aggregate Write–Ins for Personnel Expenses	This amount is carried from the detailed write–ins for personnel expenses and no entry in the spreadsheet template is required for this line. Report any other types and amounts of personnel expenses not included in lines TI03.13 through TI03.19 during the reporting period in the detailed write–in table.
TI03.21	Total Personnel Expenses	This amount is calculated and no entry is required in the spreadsheet template. This entry is the sum of Lines TI03. 13 through TI03.20 during the reporting period.
TI03.22	Title Losses Paid	Report the amount of title losses paid, net of recoveries from underwritten title companies pursuant to underwriting agreements, subrogation or errors and omissions insurance policies, during the reporting period. Do not include recoveries from reinsurance.
TI03.23	RESERVED	Leave Blank
TI03.24	RESERVED	Leave Blank
TI03.25	Change in Title Loss Reserves	Report the change in title reserves during the reporting period, including case reserves and incurred but not reported (IBNR) reserves.
TI03.26	Title Loss Adjustment Expenses	Report the amount incurred for title loss adjustment expense, net of recoveries from underwritten title companies pursuant to underwriting agreements, subrogation or errors and omissions insurance policies, during the reporting period. Do not include recoveries from reinsurance.
TI03.27	Total Title Loss and Loss Settlement Expenses	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines TI03.22 through TI03.26.
TI03.28	Escrow Losses Paid	Report the amount of escrow losses paid, net of recoveries from subrogation or errors and omissions insurance polices, during the reporting period.
TI03.29	Change in Escrow Loss Reserves	Report the change in escrow loss reserves during the reporting period.
TI03.30	Escrow Loss Adjustment Expenses	Report the amount incurred for escrow loss adjustment expenses, net of recoveries from subrogation or errors and omissions insurance policies, during the reporting period.
TI03.31	Total Escrow Loss and Loss Settlement Expenses	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines TI03.28 through TI03.30.
TI03.32	Title Plant Maintenance for Owned Title Plants	Report the amount for maintaining owned title plants during the reporting period. Do not include subscription fees or rent for non–owned plants, which is reported in Line TI03.33. Do not include amounts for customer service information, which is reported in Line TI03.50. Do not include amounts received from other licensees for title plant access as an offset to amounts incurred by the reporting company. Report any such amounts in TI03.09.
TI03.33	Subscription Fees, Rent and Charges for Non–Owned Title Plants	Report the amount for subscription fees, rent and other charges for non–owned title plants during the reporting period. Do not include amounts for customer service information, which is reported in Line TI03.50. Include only those amounts spent for title search, examination and underwriting activities. Do not include amounts received from other licensees for title plant access and use as an offset to amounts incurred by the reporting company. Report any such amounts in TI03.09.
TI03.34	Title Search/Examination and Underwriting	Report any non–personnel expenses associated with title search, examination and underwriting not otherwise reported in TI03.32 and TI03.33. Include amounts for third–party title search and examination reports.
TI03.35	Preliminary Report Production and Issuance	Report any non–personnel expenses associated with the production and issuance of preliminary reports, other than expenses for title plant and search, examination and underwriting.
TI03.36	Title Policy Issuance and Maintenance	Report any non–personnel expenses associated with the issuance of title policy, including creation of the physical title insurance policy and maintenance of information regarding the title insurance policy. Do not include expenses reported in lines TI03.32 through TI03.35.
TI03.37	Funds Transfer	Report any non–personnel expenses associated with the transfer of funds from and to parties to the real estate transaction.
TI03.38	Notary Fees	Report the amount for notary fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
TI03.39	Conveyancing Fees	Report the amount for conveyancing fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
TI03.40	Inspection Fees	Report the amount for inspection fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
TI03.41	Tax Service Contract Fees	Report the amount for tax service contract fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
TI03.42	Recording Fees and Costs	Report the amount for non–personnel recording fee expenses. Include amounts for third party recording services during the reporting period. Pass–through items – fees collected from and paid for by the consumer without mark–up — shall not be included as expenses or revenues.
TI03.43	Messenger, Overnight and Delivery Service — Preliminary Reports	Report the amount for messenger, overnight and delivery service for preliminary reports and preliminary report–related materials during the reporting period. Do not include postage and freight costs, which are reported in Line TI03.57.
TI03.44	Messenger, Overnight and Delivery Service — Title Policies	Report the amount for messenger, overnight and delivery service for title policies during the reporting period. Do not include postage and freight costs, which are reported in Line TI03.57.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI03.45	Messenger, Overnight and Delivery Service — Escrow	Report the amount for messenger, overnight and delivery service for escrow and escrow-related materials during the reporting period. Do not include postage and freight costs, which are reported in Line TI03.57.
TI03.46	Messenger, Overnight and Delivery Service — OtheR	Report the amount for messenger, overnight and delivery service other than reported in TI03.43, TI03.44 and TI03.45 and excluding any messenger and delivery expenses associated with sales, marketing or customer service, which are reported in Lines TI03.48, TI03.49 and TI03.50, respectively. Do not include postage and freight costs, which are reported in Line TI03.57.
TI03.47	Sales Expenses: Reimbursements/ Allowances for Sales Personnel	Report the amount reimbursed to sales personnel for sales and customer service expenses during the reporting period. Include allowances and reimbursements for travel expenses, such as allowance for auto or entertainment.
TI03.48	Sales Expenses: Other	Report the amount of sales expenses other than reported in Lines TI03.47 and TI03.49 during the reporting period. Include sales-related travel expenses not otherwise reported in Line TI03.47. Include amounts incurred for company-provided autos for sales personnel.
TI03.49	Business Promotion, Advertising and Public Relations	Report the amount of expenses for business promotion, advertising, and public relations during the reporting period. Do not include amounts otherwise reported in Lines TI03.47 and TI03. 48.
TI03.50	Customer Service	Report the amount of expenses for customer service, including, for example and not limited to, amounts incurred for information provided to real estate agent and brokers unrelated to specific title or escrow transactions during the reporting period.
TI03.51	Travel and Travel Items Other Than Sales, Marketing and Customer Service	Report the amount of expenses for travel and travel items, other than sales, marketing and customer service-related travel included in Lines TI03.47 through TI03.50, respectively, during the reporting period.
TI03.52	Facility Rent, Depreciation and Amortization	Report the amount of expenses for building rent for facilities used for the business of title insurance during the reporting period, net of any rental income received for those facilities. Report rent incurred for equipment in Line TI03.53. Report rental income from investment properties — facilities not used for the business of title insurance — as investment income in Line TI03.78. Include depreciation and amortization for facilities used in the business of title insurance.
TI03.53	Equipment Rent	Report the amount of expenses for renting or leasing equipment.
TI03.54	Data Processing Services and Software	Report the amount of expenses for data processing services and software. Do not include any expenses for software related to title plant access or subscription, which is reported in TI03. 33. Do not include expenses for software or data processing for, sales, marketing or customer service, which are reported in Lines TI03.48, TI03.49 and TI03.50, respectively.
TI03.55	Printing/Stationery/ Supplies	Report the amount of expenses for printing, stationery and supplies during the reporting period excluding any printing, stationery or supplies associated with sales, marketing or customer service, which are reported in Lines TI03.48, TI03.49 and TI03.50, respectively.
TI03.56	Telephone/Utilities	Report the amount for telephone and utilities during the reporting period, other than telephone expense reimbursements to sales personnel, which must be reported in Line TI03.47 and other than telephone or utilities associated with sales, marketing or customer service, which are reported in Lines TI03.48, TI03.49 and TI03.50, respectively.
TI03.57	Postage and Freight	Report the amount of expense for postage and freight during the reporting period excluding any postage and freight associated with sales, marketing or customer service, which are reported in Lines TI03.48, TI03.49 and TI03.50, respectively.
TI03.58	Accounting/Auditor Fees	Report the amount of expenses for outside auditors and accounting services during the reporting period.
TI03.59	Director Fees	Report the amount for fees to members of the company's Board of Directors during the reporting period.
TI03.60	Legal Fees	Report the amount for outside legal services, other than claim-related legal services during the reporting period. Report claim-related legal services in Lines TI03.26 and TI03.30.
TI03.61	Management Fees	Report the amount for management services during the reporting period. Do not include amounts paid to individuals. Report amounts to individuals in Line TI03.19.
TI03.62	Licenses, Fees, Taxes Other Than Income and Premium	Report the amount for licenses, regulatory fees and taxes during the reporting period. Do not include state or federal income taxes, which are reported in Lines TI03.85 and TI03.86, respectively. Do not include premium taxes which are reported in Line TI03. 63. Include property taxes only for real estate and buildings employed for the business of title insurance.
TI03.63	Premium Taxes	Report the amount of premium taxes during the reporting period.
TI03.64	Depreciation/Amortization Other Than Real Estate and Buildings	Report the amount of expenses for depreciation and amortization during the reporting period other than depreciation and amortization of real estate and buildings.
TI03.65	Bad Debt Expense	Report the amount of expenses for collecting overdue debt or for writing off bad debt during the reporting period.
TI03.66	Insurance	Report the amount for all types of insurance during the reporting period, other than insurance provided on behalf of employees, which is reported in Line TI03.17.
TI03.67	Lobbying	Report the amount for lobbying activities during the reporting period, including amounts paid to trade associations for lobbying activities. Report amounts to trade associations for activities other than lobbying in Line TI03.69.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI03.68	Donations	Report the amount of donations during the reporting period.
TI03.69	Trade Associations and Advisory Organizations	Report the amount for trade associations and advisory organizations during the reporting period.
TI03.70	Dues/Subscriptions Other than Trade and Advisory Organizations	Report the amount for dues and subscriptions other than dues and subscriptions to trade associations and advisory organizations during the reporting period
TI03.71	Fines or Penalties	Report the amount for fines, penalties and restitution to regulatory agencies, courts or to consumers pursuant to regulatory or judicial decisions or settlements during the reporting period.
TI03.72	Aggregate Write-Ins for Other Expenses	This amount is carried from the detailed write-in table below the income statement and no entry in the spreadsheet template is required for this line. Report any other types and amounts of operating expenses, not included in Lines TI03.22 through TI03.71 during the reporting period in the detailed write-in table.
TI03.73	Total Operating Expenses	This amount is calculated and no entry is required. This entry is the sum of lines TI03.22 through TI03.72.
TI03.74	Net Operating Income	This amount is calculated and no entry is required. This entry is Line TI03.11 less the sum of Lines TI03.12, TI03.21 and TI03.73.
TI03.75	Interest Paid	Report amount for interest on loans during the reporting period.
TI03.76	Investment Income — Tax Exempt	Report tax-exempt investment income before investment expenses during the reporting period.
TI03.77	Investment Income — Dividends	Report dividend investment income before investment expenses during the reporting period.
TI03.78	Investment Income — Other	Report investment income other than tax-exempt and dividend investment income before investment expenses during the reporting period. Include rental income from real estate facilities not used for the business of title insurance.
TI03.79	Investment Expenses	Report expenses associated with investment income items. Report this entry as a negative for amounts incurred.
TI03.80	Net Investment Income	This is a calculated amount and no entry in the spreadsheet template is required. This entry is the sum of lines TI03.76 through TI03.78 less line TI03.79.
TI03.81	Realized Capital Gains	Report realized capital gains during the reporting period.
TI03.82	Unrealized Capital Gains	Report unrealized capital gains during the reporting period.
TI03.83	Aggregate Write-Ins for Other Operating Expenses	This amount is carried from the detailed write-ins for other operating expenses.
TI03.84	Net Income Before Income Taxes	This amount is calculated and no entry is required in the spreadsheet template. This entry is Line TI03.74 less Line TI03.75 plus the sum of Lines TI03.80 through TI03.83.
TI03.85	Provision for State Income Taxes	Report the amount of the provision for state income taxes during the reporting period.
TI03.86	Provision for Federal Income Taxes	Report the amount of the provision for federal income taxes during the reporting period.
TI03.87	Net Income After Taxes	This amount is calculated and no entry is required in the spreadsheet template. This entry is Line TI03.84 less Lines TI03.85 and TI03.86.

(12) Data Fields for Section 2: Adjustments for Consolidation and GAAP Conversion

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI03.AA	Name of Reporting Company	Report the name of the reporting company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report TI03.
TI03.AB	Line #	Report the line number from the table in section 2356.8.(c)(11) to indicate the income or expense item being adjusted or consolidated.
TI03.AC	Line Description	Report one of the following codes: 1. Consolidation Adjustment 2. GAAP Conversion Adjustment
TI03.AD	Reporting Period	Report one of the following codes: 1. Current Year 2. Prior Year
TI03.AE	Parent Company	If entry in TI03.AC is 1 (consolidation adjustment), report the complete name of the parent company.
TI03.AF	Subsidiary Company	If entry in TI03.AC is 1 (consolidation adjustment), report the complete name of the subsidiary company.
TI03.AG	Amount of Adjustment	Report the amount of the consolidation or GAAP conversion adjustment.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI03.AH	Description of Adjustment	Provide a description of the consolidation or GAAP conversion adjustment in sufficient detail to enable a person familiar with SAP and GAAP accounting to understand the exact adjustment made. The spreadsheet template can accept detailed explanations.

(d) TI04 Detailed California Personnel Expense Report. Report TI04 is a report of personnel count and expenses on a consolidated Generally Accepted Accounting Principles (GAAP) basis. A single Report TI04 shall be submitted for a title insurance company and any of its subsidiaries which are engaged in the business of title insurance, including:

- title insurance companies;
- underwritten title companies; and
- controlled escrow companies.

(1) A title insurance company licensed in California that is a subsidiary of another title insurance company or an underwritten title company licensed in California shall not submit Report TI04, but have its experience included in the report of the parent. Stated differently, there shall be only one submission for a parent title insurance company and all its subsidiaries engaged in the business of title insurance. Any title insurance company which is not submitting a Report TI04 because that company's experience has been consolidated into a parent company's submission shall simply indicate on its (the subsidiary's) individual submission transmittal form the name of the parent company which has submitted a Report TI04 which includes the experience of the subsidiary reporting company..

(2) Two or more title insurance companies — which are not subsidiaries of one another but are affiliated with one another because they are all subsidiaries of a parent holding company which is not a title insurance company, underwritten title company or controlled escrow company — must each submit a consolidated Report TI04 for the experience of the reporting company and any subsidiary title insurance companies, underwritten title companies or controlled escrow companies.

(3) For personnel who work on California business and business elsewhere, report only that portion of the workers' time and personnel expenses associated with California-only business. Retain worksheets of worker time and expense allocations to California and to activity codes for the five most recent reporting years.

(4) Report TI04 must be submitted using the spreadsheet template provided by the Commissioner on the Department of Insurance web site: www. insurance. ca.gov.

(5) This report can be visualized as a table with each row reflecting a record of personnel expenses for a specific activity. The activity categories to be used in this report are shown in the table below. The columns of the table are data fields, described further below, which provide detail on the personnel expenses for a specific activity.

(6) Activity Codes

Assign personnel expenses to the activities described in the table. Assign a specific personnel expense only once to a single activity code.

Row/Line Number Activity Codes	*Name of Data Line*	*Description and Instructions for Data Line*
TI04.01	Title Search/Examination	This activity includes acquisition of title and related documents from a title plant or other information source, examination and analysis of the documents and underwriting. Include administrative and support staff associated with title search, examination and underwriting activities.
TI04.02	Title Plant Maintenance	This activity includes physical maintenance of a back plant and physical maintenance and updates to the current plant. This activity includes maintenance of databases and information for title and title-related documents. Include administrative and support staff associated with title plant maintenance activities.
TI04.03	Preliminary Report Issuance	This activity includes preparation and issuance of the preliminary report. This activity does not include title search, examination or underwriting, but is limited to preparation and issuance of the preliminary report after the title search, examination and underwriting have been completed. Include administrative and support staff associated with preliminary report issuance activities.
TI04.04	Title Policy Issuance and Maintenance	This activity includes preparation and issuance of the title policy and related documents and maintenance of customer information. This activity does not include title search, examination or underwriting, but is limited to preparation and issuance of the title policy after the title search, examination and underwriting have been completed. Include administrative and support staff associated with title policy issuance and maintenance activities.
TI04.05	Title Claims	This activity includes intake, processing and settling of title insurance claims. Include administrative and support staff title claims activities.
TI04.06	General Management	This activity includes general management of the title insurance company. Do not include managers of activities specifically identified in this list. Those managers shall be included with the functional activity they manage. For example, include a general counsel in this category, but do not include a lawyer dedicated to settling claims. Include human resources in the category. Include general information technology in this category — computer and network installation, maintenance and support not otherwise assigned to a separate functional category. Include any personnel devoted to developing and maintaining hardware and software for electronic access to title plant information in the Title Plant Maintenance category.
TI04.07	Customer Support	This activity includes answering questions and providing information to the title insurance company's customers or members of the public, outside of formal title search and examination and claims settlement activities. Include administrative and support staff associated with customer service activities.
TI04.08	Sales	This activity includes sales, business promotion and solicitation. Include administrative and support staff associated with sales activities.

Row/Line Number Activity Codes	*Name of Data Line*	*Description and Instructions for Data Line*
TI04.09	Escrow Document Production and Execution	This activity code includes the main activities related to escrow including preparation and execution of instruction and documents. Include administrative and support staff associated with escrow document production activities. Include personnel engaged in all escrow activities under this code other than: escrow–related general management (TI04.06) escrow–related customer service (TI04.07) escrow–related sales (TI04.08) escrow claims (TI04. 10) recording of documents (TI04.11) courier and delivery — escrow (TI04.14) funds transfer (TI04.16)
TI04.10	Escrow Claims Settlement	This activity includes processing and settling escrow claims. Include administrative and support staff associated with escrow claims settlement activities.
TI04.11	Recording of Documents	This activity includes the recording of documents as required by the transaction. Include administrative and support staff associated with recording of document activities.
TI04.12	Courier and Delivery — Preliminary Reports	This activity includes courier and delivery for preliminary reports and preliminary report–related materials. Include administrative and support staff associated with preliminary report–related courier and delivery activities.
TI04.13	Courier and Delivery — Title Policies	This activity includes courier and delivery for title policies. Include administrative and support staff associated with title policy–related courier and delivery activities.
TI04.14	Courier and Delivery — Escrow	This activity includes courier and delivery for escrow and escrow–related materials. Include administrative and support staff associated with escrow–related courier and delivery activities.
TI04.15	Courier and Delivery — Other	This activity includes any courier and delivery personnel not included in TI04.12, TI04.13 or TI04.14. Include administrative and support staff associated with other courier and delivery activities.
TI04.16	Funds Transfer	This activity includes activities specifically related to funds transfer. Include administrative and support staff associated with funds transfer activities.
TI04.17	Other Services	This activity includes any service for which a charge is made and which is not a title policy, preliminary report, full escrow or subescrow. Include administrative and support staff associated with other services activities.
TI04.18	Other	If none of the above categories can be used, use this code and explain the activity. If there are two or more types of "Other" activities, use codes 18, 19 and 20 as necessary.

(7) Include all employees, temporary/contract workers and consultants in the following reporting format. If a worker is engaged in two or more of the categories listed, estimate the percentage of the worker's time in each of the categories and allocate the worker's personnel costs on the basis of the time percentages. Assign administrative and other support workers to the category or categories for which the workers provide the support.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI04.A	Name of Title Insurer	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI04 report of the title insurance company. The Detailed California Personnel Expense Report for such a controlled escrow company reports shall be completed using the UTC04 report format.
TI04.B	Reporting Year	Report the calendar year experience period as a four–digit number.
TI04.C	Activity Category	These codes for activity categories are already entered in the spreadsheet template.
TI04.D	Description of Activity Category	If TI04.C is a code for "Other," provide a name that describes the additional activity category. For activity codes TI04.1 through TI04.17, the description is already entered into the spreadsheet template.
TI04.E	Total Full–Time Equivalent Workers	Report the total number of full–time equivalent employees, temporary/contract workers and consultants for this category during the reporting period. An employee who is engaged in each of two activity categories for 50% of his or her time would be a 0.5 full–time equivalent in each activity category. An employee who worked in one activity for only three months of the year would be a 0.25 full–time equivalent.
TI04.F	Salary	Report the aggregate salary incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for that individual worker by multiplying the total salary incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E.
TI04.G	Payroll Taxes	Report the aggregate payroll taxes incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for that individual worker by multiplying the total salary incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI04.H	Commission	Report the aggregate commission incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for that individual worker by multiplying the total commission incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E.
TI04.I	Bonus	Report the aggregate bonuses incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for individual workers by multiplying the total bonus incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E. Include in the bonus category any amounts incurred as dividends to owners who are also employees of, or independent contractors to, the company.
TI04.J	Employee Relations and Welfare	Report the aggregate benefits incurred to workers for this activity during the reporting period. Include pension contributions, health insurance, life insurance, employee training and education, food for employees and gatherings and entertainment for employees. Do not include expense allowances and reimbursements for sales personnel, which are reported in TI03. If a worker was engaged in more than one activity, calculate the amount for individual workers by multiplying the total benefits incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E.
TI04.K	Temporary Agency Workers	Report the aggregate amount paid to temporary worker agencies for personnel for this activity during the reporting period. If a worker was engaged in more than one activity, calculate the amount for individual workers by multiplying the total benefits incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E.
TI04.L	Consultants/Contract Workers	Report the aggregate benefits incurred to workers for this activity during the reporting period. Do not include amounts paid for legal or accounting services, which are reported in TI03. 60 and TI03. 58, respectively. If a worker was engaged in more than one activity, calculate the amount for individual workers by multiplying the total benefits incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in TI04.E.
TI04.M	Total Personnel Costs	Report the row sum for columns TI04. Carry these totals to the personnel expense lines in Report TI03.

(e) TI05 Detailed Escrow Report. Each title insurance company shall submit this report of escrow activity performed by the title insurance company during the reporting period. Each title insurance company shall also submit a report UTC05 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI05 of the title insurance company.

(1) Report only full escrow transactions. Do not report subescrow or escrow–related other services in Report TI05.

(2) If the reporting company provides different types of full escrow service — for example, a basic full escrow and an enhanced full escrow with some additional services included — report the escrow in Report TI05 as the basic escrow plus a surcharge. Using our example, the surcharge would be the increment in cost above the basic full escrow service and the surcharge name would be "enhanced full escrow package." In addition, report the different types of full escrow services as surcharges in Report TI11.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI05.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI05 report of the title insurance company. The Detailed Escrow Report for such a controlled escrow company reports shall be completed using the UTC05 report format.
TI05.B	Reporting Year	Report the calendar year experience period as a four–digit number.
TI05.C	Internal Transaction #	Report the internal transaction # from TI01.C for which the escrow activity is associated.
TI05.D	Number of Parties	Report the number of parties involved in the escrow.
TI05.E	Amount of Escrow	Report the total amount of the escrow. This is the value used to determine the escrow charge.
TI05.F	Basic Escrow Charge	Report the basic escrow charge to the nearest dollar without commas, periods or dollar signs. The basic escrow charge is the escrow charge before any discounts or surcharges.
TI05.G	Discount/Surcharge 1	If a discount or surcharge was applied, report the code from Report TI11 for the discount or surcharge applied.
TI05.H	Discount/Surcharge 2	If more than one discount or surcharge was applied, report the code from Report TI11 of the second discount or surcharge applied.
TI05.I	Discount/Surcharge 3	If more than two discounts or surcharges were applied, report the code from Report TI11 of the third discount or surcharge applied.
TI05.J	Discount/Surcharge 4	If more than three discounts or surcharges were applied, report the code from Report TI11 of the fourth discount or surcharge applied.
TI05.K	Discount/Surcharge 5	If more than four discounts or surcharges were applied, report the code from Report TI11 of the fifth discount or surcharge applied.
TI05.L	Total Escrow Charge	Report the total escrow charge after all discounts and surcharges.

(f) TI06 Report of Work Charges/Premium Splits Activity. Each title insurance company shall submit this report of work charges/premium splits for title, escrow and other services activity by the title insurance company during the reporting period. Each title insurance company shall also submit a report UTC06 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI05 of the title insurance company.

(1) Pursuant to Insurance Code Section 12412, a title insurance company may divide fees or charges, for work and services actually performed, between title insurance companies or between title insurance companies and underwritten title companies. A work charge or premium split refers to a payment from the reporting company to another title insurance company or to a title insurer or a payment to the reporting company from another title insurance company or underwritten title company that represents a split of the premium for division of work. Some companies refer to work charges as premium splits because the company collecting the title premium or escrow fee pays a portion of the premium or escrow fee to another company for services provided in connection with the title or escrow transaction. Work charges/premium splits refer only to payments between title insurance companies, between underwritten title companies or between underwritten title companies and title insurers and are further limited to transactions that reflect a split of the title premium or escrow charge. See the instructions for TI07 for discussion of fees paid to or received from other title insurance companies, underwritten title companies or controlled escrow companies for services received or provided and how these types of fees differ from work charges/premium splits.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI06.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI06 report of the title insurance company. The Report of Work Charges/Premium Splits Activity for such a controlled escrow company reports shall be completed using the UTC05 report format.
TI06.B	Reporting Year	Report the calendar year experience period as a four-digit number.
TI06.C	Internal Transaction #	Report the internal transaction # from TI01.C for which the work charge information is associated.
TI06.D	Work Charge Paid or Received	Report one of the following codes: 1. Work charge PAID for title services only. 2. Work charge PAID for escrow services only. 3. Work charge PAID for title and escrow services. 4. Work charge RECEIVED for title services only. 5. Work charge RECEIVED for escrow services only. 6. Work charge RECEIVED for title and escrow services. 7. Work charge PAID and RECEIVED for title services only. 8. Work charge PAID and RECEIVED for escrow services only. 9. Work charge PAID and RECEIVED for title and escrow services.
TI06.E	Description of Title Services	Describe the specific services title services provided in exchange for the work charge/premium split.
TI06.F	Description of Escrow Services	Describe the specific escrow services provided in exchange for the work charge/premium split.

(g) TI07 Report of Amounts Received from and Paid to Other Licensees and Affiliates. Each title insurance company shall submit this report of amounts received from and paid to other licensees and affiliated companies for title, escrow and other services activity by the title insurance company during the reporting period. Each title insurance company shall submit a report UTC07 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI07 of the title insurance company.

(1) This report is a description of activities, other than work charge/premium split activities, for which the reporting company received a payment for providing a service to another title insurance company, underwritten title company or controlled escrow company or made a payment to another title insurance company, underwritten title company or controlled escrow company for a service provided by the other entity. This report also includes payments to or received from affiliates, even if the affiliate is not a title insurance company, underwritten title company or controlled escrow company licensed to do business in California.

(2) Although work charge/premium split activities are a form of service provided by one licensee to another for a payment, work charge/premium split activity is not included in Report TI07. The distinction between work charges/premium split and the payments reported in this table is that work charges/premium split represent a division of premium or charges for a division of work on a specific title or escrow transaction while the activities in this report represent activities for which payment is not tied to the revenue of a specific transaction. Stated differently, this report is a description of expenses paid or revenues received by the reporting company which are not associated with a specific title or escrow order. For the company receiving the service, the activity reflects an expense item. In contrast, a work charge/premium split reflects a reduction of premium, or revenue, for the service received.

(3) There shall be a separate record for each type of service provided or received and for each entity to whom the service was provided or from whom the service was received. For example, if the reporting company provided the same service to two underwritten title companies, there shall be two records for that activity — one for each company to whom the service was provided.

(4) This report can be visualized as a table with each row or record as a summary of information about a specific type of other service and with each column a different data field. The instructions below explain the entries in each data field or column.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI07.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI07 report of the title insurance company. The Report of Amounts Received from and Paid to Other Licensees for such a controlled escrow company reports shall be completed using the UTC07 report format.
TI07.B	Reporting Year	Report the calendar year experience period as a four-digit number.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI07.C	Name of Entity Paid or from Which Payment Was Received	Report the name of the title insurance company, underwritten title company or controlled escrow company to which a payment was made for services provided by that entity or from whom a payment was received for services provided to that entity. There shall be a separate record for each type of service provided or received and for each entity to whom the service was provided or from whom the service was received. For example, if the reporting company provided the same service to two underwritten title companies, there shall be two records for that activity — one for each company to whom the service was provided. Do not include work charges/premium splits in this report. Work charges/premium splits are reported in TI09. A work charge represents a division of the title premium or escrow fee for the division of work to perform title or escrow. This table is a report of expenses and revenues for services provided outside of the premium split arrangement.
TI07.D	Affiliated, Non–Affiliated and Licensee	Report one of the following codes to describe the type of entity named in TI07.C: 1. Affiliated title insurance company, underwritten title company or controlled escrow company licensed to do business in California. 2. Affiliated company other than a title insurance company, underwritten title company or controlled escrow company licensed to do business in California. 3. Non–affiliated company title insurance company, underwritten title company or controlled escrow company licensed to do business in California.
TI07.E	Expense or Revenue	Report one of the following codes: 1 — if the reporting company paid for a service 2 — if the reporting company received revenue for a service
TI07.F	Description of Activity	Describe the service provided with moderate detail. "Title Search" or "Escrow" or "Management Services" are insufficient descriptions.
TI07.G	Category	If the item is an expense — the entry in TI07.D is 1 — report the line from Report TI03 in which the item is reported for non–personnel expenses and the line from Report TI04 in which the item is reported for personnel expenses. If the item is revenue — the entry in TI07.D is 2 — report the line from Report TI03 in which the revenue is reported.
TI07.H	Amount Paid	If the entry in data field TI07.E is 1, report to the nearest dollar the total amount paid for the activity in data field TI07.F provided to the entity in data field TI07.C during the reporting period. If the entry in data field TI07.D is 2, report to the nearest dollar the total amount received for the activity in data field TI07.E from the entity in data field TI07.C during the reporting period.
TI07.I	Special Nature of Affiliate	Enter 1 if the affiliate in this transaction received a benefit from a lending institution where the benefit was derived from the lending institution's absorption of expenses incident to providing a normal banking function or the lending institution's forbearance from charging a fee in connection with providing a normal banking function. Otherwise, leave blank.

(h) TI08 Report of Other Services Activity. Each title insurance company shall submit this report of other services activity during the reporting period. Each title insurance company shall submit a report UTC08 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI08 of the title insurance company.

(1) Other services include any activity for which a charge is made to one of the parties in the real estate transaction and which is not the production or delivery of a preliminary report, the production or delivery of a title insurance policy, the provision of full escrow or the provision of subescrow.

(2) This report can be visualized as a table with each row or record as a summary of information about a specific type of other service and with each column a different data field. The instructions below explain the entries in each data field or column.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI08.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI08 report of the title insurance company. The Report of Other Services Activity for such a controlled escrow company shall be completed using the UTC08 report format.
TI08.B	Reporting Year	Report the calendar year experience period as a four–digit number.
TI08.C	Internal Transaction #	Report the internal transaction # from TI01.C for which the other service charge activity is associated. If the other services are associated with a transaction not reported in table TI01, create a new and unique transaction number for use with this report.
TI08.D	Other Service	Report the name of the other service provided. Other services include any service for which a charge is made and which is not the provision of a preliminary report, a title policy, full escrow or subescrow. Report a separate record for each other service provided. For example, if three other services were provided in connection with a particular transaction number, there will be three records, all of which have the same transaction number in line TI08.C. If four other services were provided in connection with a particular transaction #, there will be four records with the same transaction # in TI08.C
TI08.E	Other Service Category	Report one of the following codes to describe the other service: 1. Preliminary Report–related 2. Title Policy Issuance–related 3. Escrow–related 4. Other
TI08.F	Other Service Charge	Report the amount of the charge for the other service described in line TI08.D.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI08.G	Other Service Charge Date of Rate Filing	Report the submission date of the rate filing in which the other service charge is listed in YYYYMMDD format where YYYY is the year, MM is the month and DD is the day.
TI08.H	Filing Page Number	Report the page number of the rate filing from field TI08.F on which the charge for the other service from field TI05.D can be found.

(i) TI09 Report of Facilities Locations. Each title insurance company shall submit this report of facilities locations employed by the title insurance company for California–related title, escrow and other services activities. Each title insurance company shall submit a report UTC09 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI09 of the title insurance company.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI09.A	Name of Reporting Entity	Report the name of the title insurance company whose facilities are reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose facilities are not otherwise included in the TI09 report of the title insurance company. The Report of Facilities Locations for such a controlled escrow company reports shall be completed using the UTC09 report format.
TI09.B	Reporting Year	Report the calendar year experience period as a four–digit number.
TI09.C	Office Code	Report a unique numerical code of up to five digits for each office location of the reporting entity. Office refers to any location in which the business of title insurance is transacted and includes locations where title plants are housed, where title search and examination is conducted, where title policies are produced and issued from, where escrow is conducted, where other services are performed and where any aspect of the business of title insurance is conducted. Report the numerical code without comma or leading zeroes. Report a separate record for each office location.
TI09.D	Office Street Address	Report the street address of the office whose code is reported in field TI09.B.
TI09.E	Office City	Report the city location of the office whose code is reported in field TI09.B.
TI09.F	Office State	Report the state location of the office whose code is reported in field TI09.B. Report the United States Post Office two letter state abbreviation in capital letters.
TI09.G	Office 5 Digit ZIP	Report the 5–digit ZIP Code location of the office whose code is reported in field TI09.B. Report the 5 digits without commas and use a leading zero when appropriate.
TI09.H	Office Plus 4 ZIP	Report the Plus–4 ZIP Code location of the office whose code is reported in field TI09.B.
TI09.I	Foreign Location	If the office location is outside of the United States, report the city, state or province, and country location of the office whose code is reported in field TI09.B.
TI09.J	Location Activity: Title Search and Examination	Report the average number of full–time equivalent workers engaged in title search, examination and underwriting at this location during the reporting period.
TI09.K	Location Activity: Title Plant	Report the average number of full–time equivalent workers engaged in title plant maintenance at this location during the reporting period.
TI09.L	Location Activity: Preliminary Report Production and Issuance	Report the average number of full–time equivalent workers engaged in preliminary report production and issuance activities — not title plant maintenance or title search, examination or underwriting — at this location during the reporting period.
TI09.M	Location Activity: Title Policy Production and Issuance	Report the average number of full–time equivalent workers engaged in title policy production and issuance at this location during reporting period. Do not include workers engaged in title plant maintenance, title search, examination and underwriting or preliminary report production and issuance.
TI09.N	Location Activity: Escrow Closing	Report the average number of full–time equivalent workers engaged in escrow closing activities at this location during the reporting period.
TI09.O	Location Activity: Escrow Other Than Closing	Report the average number of full–time equivalent workers engaged in escrow activities other than escrow closing at this location during the reporting period.

(j) TI10 Report of Title Premium by Underwritten Title Company. Each title insurance company shall submit this report of title insurance premium going to underwritten title companies pursuant to underwriting agreements during the reporting period. This report can be visualized as a table with each row (record) describing the title insurance premium generated by a single underwritten title company and each column representing the data fields described below.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI10.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company.
TI10.B	Reporting Year	Report the calendar year experience period as a four–digit numeral.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI10.C	Name of UTC	Report the name of the underwritten title company to whom a portion of the title insurance premium was paid. Report all direct business — business for which a title policy was issued and premium received by the reporting company without any involvement of an underwritten title company — in a separate record (row) and enter "Direct" in this data field.
TI10.D	Gross Title Premium	Report the total amount of title premium during the reporting period for policies issued with the assistance of the UTC listed in data field TI10.C. Report the total amount of title premium on direct business in the record (row) where the entry in TI10.C is Direct.
TI10.E	Amount to UTC	Report the total amount of the title premium from data field TI10.D that went to the UTC listed in data field TI10.C.
TI10.F	Amount to Reporting Company	Report the total amount of the title premium from data field TI10.D that went to the reporting company.

(k) TI11 Report of Escrow Discounts and Surcharges. Each title insurance company shall submit this report of escrow discounts and surcharges used during the reporting period. Each title insurance company shall submit a report UTC11 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI11 of the title insurance company.

(1) This report can be visualized as a table with each row (record) describing a different title policy form endorsement and each column representing the data fields described below.

(2) Rates for different geographic locations shall be reported as discounts and surcharges of a base escrow rate.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI11.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company. A separate report is required for each controlled escrow company which is controlled by the title insurance company and whose experience is not otherwise included in the TI11 report of the title insurance company. The Report of Escrow Discounts and Surcharges for such a controlled escrow company reports shall be completed using the UTC11 report format.
TI11.B	Reporting Year	Report the calendar year experience period as a four-digit number.
TI11.C	Code	Report a unique code for each escrow discount and surcharge.
TI11.D	Name	Report a description of the discount or surcharge associated with the unique code from field TI11.C.
TI11.F	Type of Rate	Describe the type of rate by entering one of the following codes: 1. if the rate is a percentage of an amount in a basic rate table; 2. if the rate is a fixed dollar amount; 3. if the rate is a percentage of the basic premium; or 4. if other than 1, 2 or 3.
TI11.G	Rate	If the code in TI15.F is 1, report the percentage as a whole number. For example, if the rate is 64% of the basic rate table, report 64. If the code in TI15.F is 2, report the dollar amount to the nearest whole dollar without commas. If the code in TI15.F is 3, report the percentage as a whole number. If the code in TI15.F is 4, report a description of the rate.

(*l*) TI12 Six-Year Report of Selected Data. Each title insurance company submitting Reports TI02 and TI03 shall submit this report of six years of experience for certain line items from Reports TI02 and TI03. Report TI12, like Reports TI02 and TI03, is a report of consolidated GAAP-basis experience.

(1) Report TI12 must be reported using a spreadsheet template provided by the Commissioner on the Department's web site: www.insurance.ca.gov.

(2) Descriptions and Instructions for Data Fields

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI12.A	Name of Reporting Company	Report the name of the reporting company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report TI02.
TI12.B	Current Reporting Year — California	Report experience for the current — most recent — reporting period in this column for California-only business. The entries in this column are carried from Table TI02, Column TI02.D and Table TI03, Column TI03.D for line items in those reports that match the line items in this report.
TI12.C	First Prior Year — California	Report experience for the first reporting period prior to the current reporting period for California-only business in this column. The entries in this column are carried from Table TI02, Column TI02.E and Table TI03, Column TI03.F for line items in those reports that match the line items in this report.
TI12.D	Second Prior Year — California	Report experience for the second reporting period prior to the current reporting period for California-only in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI12.E	Third Prior Year — California	Report experience for the third reporting period prior to the current reporting period for California–only in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period.
TI12.F	Fourth Prior Year — California	Report experience for the fourth reporting period prior to the current reporting period for California–only business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period.
TI12.G	Fifth Prior Year — California	Report experience for the fifth reporting period prior to the current reporting period for California–only business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets and liabilities employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period. No expense item row entries are required for this reporting period (column).
TI12.H	Current Year — Countrywide	Report consolidated GAAP–basis experience for the current — most recent — reporting period for countrywide business in this column. The entries in this column are carried from Table TI02, Column TI02.H and Table TI03, Column TI03.H for line items in those reports that match the line items in this report.
TI12.I	First Prior Year — Countrywide	Report consolidated GAAP–basis experience for the first reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are carried from Table TI02, Column TI02.I and Table TI03, Column TI03.I for line items in those reports that match the line items in this report.
TI12.J	Second Prior Year — Countrywide	Report consolidated GAAP–basis experience for the second reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period.
TI12.K	Third Prior Year — Countrywide	Report consolidated GAAP–basis experience for the third reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period.
TI12.L	Fourth Prior Year — Countrywide	Report consolidated GAAP–basis experience for the fourth reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period.
TI12.M	Fifth Prior Year — Countrywide	Report consolidated GAAP–basis experience for the fifth reporting period prior to the current reporting period for total countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table TI02 and Table TI03. Stated differently, the same procedures used to allocate assets and liabilities employed in Table TI02 and Table TI03 must be used to develop the entries for this earlier period. No expense item row entries are required for this reporting period (column).

(3) Descriptions and Instructions for Data Fields

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI12.01	Year	Enter the year corresponding to the reporting year for each column as a four digit number without commas. For example, if the current reporting period is 2010, enter 2010 in this row in Column TI12.B and 2009, 2008, 2007, and 2006 in Columns TI12.C, TI12.D, TI12.E and TI12.F. In this example, enter 2010, 2009, 2008, 2007, and 2006 in Columns TI12.G, TI12.H, TI12.I, TI12.J and TI12.K, respectively.
TI12.02	Gross Title Premium	Report gross title premium in the same manner as reported in TI03.01.
TI12.03	Escrow Fees	Report full escrow fees in the same manner as reported in TI03.04.
TI12.04	Subescrow Fees	Report subescrow fees in the same manner as reported in TI03.05
TI12.05	Other Service Charges	Report other service revenues in the same manner as reported in TI03.08
TI12.06	Total Operating Revenue	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of rows TI12.02 through TI12.05. Report total operating revenue including title insurance premiums, escrow fees, other service charges and other operating revenue during the reporting period.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
TI12.07	Total Title Loss and Loss Settlement Expenses	Report title loss and loss settlement expenses in the same manner as reported in TI03.27, which is the sum of title losses paid, changes in title loss case reserves and title loss adjustment expenses.
TI12.08	Total Escrow Loss and Loss Settlement Expenses	Report escrow loss and loss settlement expenses in the same manner as reported in TI03.31, which is the sum of escrow losses paid, changes in escrow loss reserves and escrow loss adjustment expenses.
TI12.09	Net Investment Income	Report net investment income in the same manner as reported in TI03.79.
TI12.10	Realized Capital Gains	Report realized capital gains in the same manner as reported in TI03.80.
TI12.11	Unrealized Capital Gains	Report unrealized realized capital gains in the same manner as reported in TI03.80.
TI12.12	Net Income Before Taxes	Report net income before taxes in the same manner as reported in TI03.83
TI12.13	State Income Tax	Report state income taxes in the same manner as reported in TI03. 84.
TI12.14	Federal Income Tax	Report federal income taxes in the same manner as reported in TI03.85.
TI12.15	RESERVED	Leave Blank
TI12.16	Goodwill	Report goodwill in the same manner as reported in TI02.09
TI12.17	RESERVED	Leave Blank
TI12.18	Total Assets	Report total assets in the same manner as reported in TI02.12
TI12.19	Title Case Loss Reserves	Report title case loss reserves in the same manner as reported in TI02.19.
TI12.20	Title Incurred But Not Reported Loss Reserves	Report title incurred but not reported loss reserves in the same manner as reported in TI02.20.
TI12.21	Escrow Claim Reserves	Report escrow claim reserves in the same manner as reported in TI02.21.
TI12.22	Total Reserves	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of TI12.19, TI12.20 and TI12.21.
TI12.23	RESERVED	Leave Blank
TI12.24	Total Liabilities	Report total liabilities in the same manner as reported in TI02.24.
TI12.25	RESERVED	Leave Blank
TI12.26	Total Equity	Report total equity in the same manner as reported in TI02.29
TI12.27	Total Reserves and Equity	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of TI12.22 and TI12.26.
TI12.28	Total Liabilities and Equity	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of TI12.24 and TI12.26.

(m) TI13 Report of Unusual Charges. Each title insurance company shall submit this report of unusual charges made pursuant to Insurance Code Section 12401.8. Each title insurance company shall submit a report UTC13 for each controlled escrow company controlled by the title insurance company and whose experience is not otherwise included in the report TI13 of the title insurance company. This report can be visualized as a table where each row is a separate record corresponding to a separate unusual charge and each column is a separate data field.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI13.A	Name of Reporting Company	Enter the full name of the reporting company.
TI13.B	Reporting Period	Enter the experience year as a four–digit number without commas.
TI13.C	Transaction #	Enter the transaction number from Report TI01 that contains this unusual charge.
TI13.D	Risk or Service	Enter 1 of the following codes to describe the unusual charge: 1. for unusual risk 2. for unusual charge
TI13.E	Amount	Enter the dollar amount for the unusual charge with no commas.
TI13.F	Description	Provide a complete description of the unusual coverage or unusual service provided.
TI13.G	Cost Justification	Provide a brief cost justification for the unusual charge.

(n) TI14 Detailed Policy Report. Each title insurance company shall submit this report of detailed title policy information for policies issued during the reporting period. This report can be visualized as a table where each row is a separate record corresponding to a separate transaction and each column is a separate data field. For this report, a transaction is the issuance of a title policy. Each policy issuance is a separate transaction with the exception of concurrently–issued owner's and lender's policies for the same property. A concurrent issue of an owner's and lender's policy shall be reported as one transaction and, consequently, as one record in this table. The columns of the table are data fields, which are described below.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI14.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported.
TI14.B	Reporting Year	Report the calendar year experience period as a four–digit numeral.
TI14.C	Policy Transaction #	Report a transaction number or code to identify the title policy information associated with a particular title policy issuance transaction. Each policy issuance is a separate transaction with the exception of concurrently–issued owner's and lender's policies for the same property. A concurrent issue of an owner's and lender's policy shall be reported as one transaction and, consequently, as one record in this table.
TI14.D	Type of Real Estate Transaction	Report one of the following codes: 1. Residential Sale — New Home 2. Residential Sale — Resale of Existing Home 3. Residential Sale — Land Only 4. Residential Refinance 5. Residential Home Equity 6. Commercial or Industrial Sale 7. Commercial or Industrial Refinance 8. Other
TI14.E	UTC Involvement	Report one of the following codes: 1. Policy issued directly without involvement of underwritten title company. 2. Policy issued with assistance of affiliated underwritten title company. 3. Policy issued with assistance of non–affiliated underwritten title company.
TI14.F	Name of UTC	If the entry in data field TI14.E is 2 or 3, report the name of the underwritten title company involved in the transaction.
TI14.G	Street Address of Property	Report the street address of the property that is the subject of the transaction.
TI14.H	City	Report the city location of the property that is the subject of the transaction
TI14.I	County	Report the county location of the property that is the subject of the transaction.
TI14.J	ZIP Code	Report the 5–Digit ZIP Code location of the property that is the subject of the transaction as XXXXX.
TI14.K	Date of Policy Issuance	Report the date of policy issuance in YYYYMMDD format.
TI14.L	Owner's Policy Form	Report the policy form code from report TI17 corresponding to the owner's policy form issued.
TI14.M	Owner's Policy Amount of Insurance	Report the amount of insurance on the owner's policy to the nearest dollar with no commas.
TI14.N	Owner's Policy Basic Premium	Report the amount of the premium, before addition of endorsement premium and before the application of discounts or surcharges, to the nearest dollar with no commas.
TI14.O	Lender's Policy 1 Form	Report the policy form code from report TI17 corresponding to the first lender's policy form issued.
TI14.P	Lender's Policy 1 Amount of Insurance	Report the amount of insurance on the first lender's policy to the nearest dollar with no commas.
TI14.Q	Lender's Policy 1 Basic Premium	Report the amount of the premium on the first lender's policy, before addition of endorsement premium and before the application of discounts or surcharges, to the nearest dollar with no commas.
TI14.R	Lender's Policy 2 Form	If two or more lenders' policies were issued, report the policy form code from report TI17 corresponding to the second lender's policy form issued.
TI14.S	Lender's Policy 2 Amount of Insurance	Report the amount of insurance on the second lender's policy to the nearest dollar with no commas.
TI14.T	Lender's Policy 2 Basic Premium	Report the amount of the premium for the second lender's policy, before addition of endorsement premium and before the application of discounts or surcharges, to the nearest dollar with no commas.
TI14.U	Discount/Surcharge 1	If a discount or surcharge was applied, report the code from Report TI17 corresponding to the discount or surcharge applied.
TI14.V	Discount/Surcharge 2	If more than one discount or surcharge was applied, report the code from Report TI17 corresponding to the second discount or surcharge applied.
TI14.W	Discount/Surcharge 3	If more than two discounts or surcharges were applied, report the code from Report TI17 corresponding to the third discount or surcharge applied.
TI14.X	Discount/Surcharge 4	If more than three discounts or surcharges were applied, report the code corresponding to the fourth discount or surcharge applied.
TI14.Y	Endorsement 1	If an endorsement was added to the policy form or forms, report the endorsement code from report TI17 corresponding to the endorsement added.
TI14.Z	Endorsement 2	If more than one endorsement was added to a policy form or forms, report the endorsement code from report TI17 corresponding to the second endorsement added.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI14.AA	Endorsement 3	If more than two endorsements were added to a policy form or forms, report the endorsement code from report TI17 corresponding to the third endorsement added.
TI14.AB	Endorsement 4	If more than three endorsements were added to a policy form or forms, report the endorsement code from report TI17 corresponding to the fourth endorsement added.
TI14.AC	Endorsement 5	If more than four endorsements were added to a policy form or forms, report the endorsement code from report TI17 corresponding to the fifth endorsement added.
TI14.AD	Total Premium for Title Policy or Policies	Report the total premium charged for the title policy or policies.
TI14.AE	Amount Paid to UTC per Underwriting Agreement	Report the amount of the total premium paid to an underwritten title company pursuant to an underwriting agreement.

(o) TI15 Detailed Claim Report. Each title insurance company shall submit this report of detailed claim experience during the reporting period. All claim activity during the reporting period shall be included in this report, including claim payments, claim recoveries, claim settlements without payment, claims denied and establishment or adjustment of reserves. This report can be visualized as a table where each row is a separate record of activity during the reporting year for an individual claim. The columns of the table are data fields, described below.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI15.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company.
TI15.B	Reporting Year	Report the calendar year experience period as a four-digit numeral.
TI15.C	Date Policy Issued	Report the date of issuance of the policy under which the claim was made in YYYYMMDD. For example, report May 15, 2010 as "20100515" without the quotation marks.
TI15.D	Type of Real Estate Transaction	Report one of the following codes: 1. Residential Sale — New Home 2. Residential Sale — Resale of Existing Home 3. Residential Sale — Land Only 4. Residential Refinance 5. Residential Home Equity 6. Commercial or Industrial Sale 7. Commercial or Industrial Refinance 8. Other
TI15.E	Owner's or Lender's Policy	Report 1 if an owner's policy, 2 if a lender's policy or 3 if neither an owner's or lender's policy. Policy refers to the policy under which the claim was made.
TI15.F	Type of Policy Form	Report the policy form code from report TI15 corresponding to the policy under which the claim was made. If the policy under which the claim was made is not included in report TI15, report the name of the policy form with sufficient detail to identify the policy form under which the claim was made.
TI15.G	Amount of Insurance	Report the amount of insurance on the policy. Report the amount without comma or dollar signs. For example, report a liability of $542,000 as "542000" without the quotation marks.
TI15.H	Endorsement	If the claim is made under coverage provided by an endorsement, report the endorsement code from report TI15 corresponding to the endorsement providing the coverage sought by the claimant. If the endorsement under which the claim was made is not included in report TI15, report the name of the endorsement with sufficient detail to identify the endorsement under which the claim was made.
TI15.I	ALTA Risk Code	Report the type of claim using the American Land Title Association Claims Codes, February 2002 edition, which are incorporated in these regulations by this reference. That document or a link to the document is available on the California Department of Insurance web site.
TI15.J	Claim Denied	If the claim was denied, please report the reason for denial.
TI15.K	Amount Paid	Report the dollar amount paid on this claim by the end of the reporting period.
TI15.L	Amount Reserved	Report the dollar amount of any claim reserve established for this claim at the end of the reporting period.
TI15.M	Loss Adjustment Expenses Paid	Report the dollar amount of any amount of loss adjustment expense paid on this claim by the end of the reporting period.
TI15.N	Loss Adjustment Expense Reserve	Report the dollar amount of any loss adjustment expense reserve established for this claim at the end of the reporting period.
TI15.O	UTC Recoveries	Report the dollar amount of any recoveries on this claim obtained from underwritten title companies by the end of the reporting period.
TI15.P	Other Recoveries	Report the dollar amount of any recoveries on this claim obtained from any source other than an underwritten title company by the end of the reporting period.

(p) TI16 Loss Development Report. Each title insurance company shall submit a Report TI16, which is a 20–year loss development report for California–only business. Report TI16 is similar to several of the Schedules P in the Statutory Annual Statement, but Report TI16 consolidates several Schedules P into one report or table and is limited to California–only business while the Schedules P are countrywide experience.

(1) Report TI16 is set up as a typical loss development report with rows and columns representing policy year experience. Lines TI16.001 through TI16.004 contain summary policy year information for Gross Written Title Premium, Gross Earned Title Premium, Amount of Insurance and Paid Unallocated Loss Adjustment Expenses. Paid Unallocated Loss Adjustment Expense may require an allocation of countrywide ULAE to California.

(A) Rows TI16.005 through TI16.024 is a 20–year loss development table for number of paid claims.

(B) Rows TI16.025 through TI16.044 is a 20–year loss development table for paid losses before recoveries from underwritten title companies.

(C) Rows TI16.045 through TI16.064 is a 20–year loss development table for paid losses net of recoveries from underwritten title companies and any other entity.

(D) Rows TI16.065 through TI16.084 is a 20–year loss development table for claim case reserves.

(E) Rows TI16.085 through TI16.104 is a 20–year loss development table for paid allocated loss adjustment expenses.

(F) Rows TI16.105 through TI16.124 is a 20–year loss development table for allocated loss adjustment expense case reserves.

(2) Reporting companies shall keep worksheets for Report TI16, including, for example, any ULAE allocation calculations for the five most recent annual Report TI16 submissions.

(3) Report TI16 must be reported using the spreadsheet template provided by the Department and available on the Department's web site: www.insurance.ca.gov.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI16.A	Reporting Company	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company.
TI16.B	Line #	Report the line number from the table below for Report TI16. The line numbers are pre–entered in the spreadsheet template.
TI16.C	Line Description	Report the line description corresponding to the line number in TI16.B. The line descriptions are pre–entered in the spreadsheet template.
TI16.D	19th Prior Year	The current year is the most recent calendar year. The 19th prior year is nineteen years earlier. For example, if the most recent calendar year is 2010, then the 19th prior year is 1991. Enter the year as a four–digit number without a comma.
TI16.E	18th Prior Year	The current year is the most recent calendar year. The 18th prior year is eighteen years earlier. For example, if the most recent calendar year is 2010, then the 18th prior year is 1992. Enter the year as a four–digit number without a comma.
TI16.F	17th Prior Year	The current year is the most recent calendar year. The 17th prior year is seventeen years earlier. For example, if the most recent calendar year is 2010, then the 17th prior year is 1993. Enter the year as a four–digit number without a comma.
TI16.G	16th Prior Year	The current year is the most recent calendar year. The 16th prior year is sixteen years earlier. For example, if the most recent calendar year is 2010, then the 16th prior year is 1994. Enter the year as a four–digit number without a comma.
TI16.H	15th Prior Year	The current year is the most recent calendar year. The 15th prior year is fifteen years earlier. For example, if the most recent calendar year is 2010, then the 15th prior year is 1995. Enter the year as a four–digit number without a comma.
TI16.I	14th Prior Year	The current year is the most recent calendar year. The 14th prior year is fourteen years earlier. For example, if the most recent calendar year is 2010, then the 14th prior year is 1996. Enter the year as a four–digit number without a comma.
TI16.J	13th Prior Year	The current year is the most recent calendar year. The 13th prior year is thirteen years earlier. For example, if the most recent calendar year is 2010, then the 13th prior year is 1997. Enter the year as a four–digit number without a comma.
TI16.K	12th Prior Year	The current year is the most recent calendar year. The 12th prior year is twelve years earlier. For example, if the most recent calendar year is 2010, then the 12th prior year is 1998. Enter the year as a four–digit number without a comma.
TI16.L	11th Prior Year	The current year is the most recent calendar year. The 11th prior year is eleven years earlier. For example, if the most recent calendar year is 2010, then the 11th prior year is 1999. Enter the year as a four–digit number without a comma.
TI16.M	10th Prior Year	The current year is the most recent calendar year. The 10th prior year is ten years earlier. For example, if the most recent calendar year is 2010, then the 10th prior year is 2000. Enter the year as a four–digit number without a comma.
TI16.N	9th Prior Year	The current year is the most recent calendar year. The 9th prior year is nine years earlier. For example, if the most recent calendar year is 2010, then the 9th prior year is 2001. Enter the year as a four–digit number without a comma.
TI16.O	8th Prior Year	The current year is the most recent calendar year. The 8th prior year is eight years earlier. For example, if the most recent calendar year is 2010, then the 8th prior year is 2002. Enter the year as a four–digit number without a comma.
TI16.P	7th Prior Year	The current year is the most recent calendar year. The 7th prior year is seven years earlier. For example, if the most recent calendar year is 2010, then the 7th prior year is 2003. Enter the year as a four–digit number without a comma.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI16.Q	6th Prior Year	The current year is the most recent calendar year. The 6th prior year is six years earlier. For example, if the most recent calendar year is 2010, then the 6th prior year is 2004. Enter the year as a four–digit number without a comma.
TI16.R	5th Prior Year	The current year is the most recent calendar year. The 5th prior year is five years earlier. For example, if the most recent calendar year is 2010, then the 5th prior year is 2005. Enter the year as a four–digit number without a comma.
TI16.S	4th Prior Year	The current year is the most recent calendar year. The 4th prior year is four years earlier. For example, if the most recent calendar year is 2010, then the 4th prior year is 2006. Enter the year as a four–digit number without a comma.
TI16.T	3rd Prior Year	The current year is the most recent calendar year. The 3rd prior year is three years earlier. For example, if the most recent calendar year is 2010, then the 3rd prior year is 2007. Enter the year as a four–digit number without a comma.
TI16.U	2nd Prior Year	The current year is the most recent calendar year. The 2nd prior year is two years earlier. For example, if the most recent calendar year is 2010, then the 2nd prior year is 2008. Enter the year as a four–digit number without a comma.
TI16.V	1st Prior Year	The current year is the most recent calendar year. The 1st prior year is one year earlier. For example, if the most recent calendar year is 2010, then the 1st prior year is 2009. Enter the year as a four–digit number without a comma.
TI16.W	Current	The current year is the most recent calendar year. Enter the year as a four–digit number without a comma.

(q) TI17 Report of Title Insurance Policy Forms, Endorsements, Discounts and Surcharges. Each title insurance company shall submit this report of title insurance policy forms, endorsements, discounts and surcharges used during the reporting period. This report can be visualized as a table with each row (record) describing a different title policy form and each column representing the data fields described below.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
TI17.A	Name of Reporting Entity	Report the name of the title insurance company whose experience is being reported. A separate report is required for each title insurance company.
TI17.B	Reporting Year	Report the calendar year experience period as a four–digit numeral.
TI17.C	Type of Record	Report 1 if the record describes a policy form, 2 if the record describes an endorsement, and 3 if the record describes a discount or surcharge.
TI17.D	Code	Report a unique code for each policy form, endorsement, discount and surcharge.
TI17.E	Name	Report the name/description of the policy form, endorsement, discount or surcharge associated with the unique code from field TI17.D. For policy forms and endorsements, report the full name of the policy form or endorsement and the year approved for use. For discounts or surcharges, report a description of the discount or surcharge.
TI17.F	Rate Filing Location	Report the date and page number of the rate filing in which the rate can be found. Report in the format YYYYMMDD PPP, where YYYYMMDD is the four–digit year, month and day followed by a space and then the page number, where the page number can be a number or letter and number combination. For example, 20100501E17.
TI17.G	Owner's or Lender's	If applicable, report whether the form, endorsement, discount or surcharge is, or applies to, an owner's policy, a lender's policy or both, using the following codes: 1 if the form is an owner's policy or if the endorsement, discount or surcharge applies only to an owner's policy 2 if the form is a lender's policy or if the endorsement, discount or surcharge applies only to a lender's policy 3 if the form is lender's or owner's policy or the endorsement, discount or surcharge can apply to an owner's policy or a lender's policy
TI17.H	Standard or Extended Coverage	Report one of the following codes to describe policy forms 1 if standard coverage 2 if extended coverage 3 if greater than extended coverage 4 if other than 1, 2 or 3
TI17.I	Type of Rate	Describe the type of rate by entering one of the following codes: 1 if the rate is a percentage of an amount in a basic rate table 2 if the rate is a fixed dollar amount 3 if the rate is a percentage of the basic premium 4 if other than 1, 2 or 3
TI17.J	Rate	If the code in TI17.I is 1, report the percentage as a whole number. For example, if the rate is 64% of the basic rate table, report 64. If the code in TI1 7.I is 2, report the dollar amount to the nearest whole dollar without commas. If the code in TI17.I is 3, report the percentage as a whole number. If the code in TI17.I is 4, report a description of the rate.

NOTE: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 1215, 12401.1, 12401.2, 12401.8 and 12412, Insurance Code.

HISTORY

1. New section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2356.9. Annual Financial Data Requirements for Underwritten Title Company Reports.

(a) UTC01 Title and Escrow Transaction Report. Each underwritten title company shall submit this report of title, escrow and other services transactions by the underwritten title company during the reporting period. Include transactions that were opened in previous years and which were closed or cancelled during the reporting period. Include transactions that were opened during the reporting period whether or not the transactions were closed, cancelled or remained open at the end of the reporting period. Each underwritten title company shall submit a report UTC01 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC01 of the underwritten insurance company.

(1) This report can be visualized as a table where each row is a separate record corresponding to a separate transaction and each column is a separate data field. For this report, a transaction is the set of activities associated with a single property transaction. For example — for this report — a transaction might consist of title, escrow and other service activities if all those activities were performed for the same property transaction. Or the transaction might consist of only title activity if, for example, a preliminary report was the only activity performed for the particular property transaction. A transaction may consist of any combination of title, escrow and other services activities to the extent one or more of the activities were performed for a single property transaction. The data fields described for this report, below, can be visualized as the columns in a table.

(2) A transaction that involves a work charge/premium split — described in the instructions for column UTC01.F — shall be reported by both organizations involved in that transaction reflecting their respective activities in the transaction. For example, if a title insurer and an underwritten title company or if two underwritten title companies employed a work charge/premium split for a title policy on a particular real estate transaction, both organizations shall report their respective activities on that transaction in their respective Title and Escrow Transaction Reports.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC01.A	Name of Reporting Entity	Report the name of the underwritten title company. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC01 report of the underwritten title company. The Title and Escrow Transaction Report for such a controlled escrow company reports shall be completed using the UTC01 report format.
UTC01.B	Reporting Year	Report the calendar year experience period as a four-digit number. Report experience during the reporting period.
UTC01.C	Internal Transaction #	Report the internal transaction number or code used to identify this transaction from other transactions. If no such internal transaction numbers are used, create a unique number or code for each transaction.
UTC01.D	Type of Title and Escrow Transaction	Report one of the following codes. Title refers to a preliminary report, title policy, title guaranty or other activity regarding the assurance of title. Full escrow refers to the complete set of escrow activities associated with a typical residential transaction including, at a minimum: • Serving as the liaison to all parties in the transaction; • Preparing escrow instructions; • Requesting a preliminary title search or title commitment to determine the present condition of title to the property; • Complying with the lender's requirements as specified in the escrow agreement; • Receiving purchase funds from the buyer; • Preparing or securing the deed or other documents related to escrow; • Prorating taxes, interest, insurance and rents according to instructions; • Securing releases of all contingencies or other conditions required; • Recording deeds and any other documents as instructed; • Closing escrow when all instructions from buyer and seller have been carried out; • Disbursing authorized funds; and • Preparing final statement Subescrow refers to funds transfer for lenders in those situations where an entity other than the reporting company is performing other escrow activities. Subescrow typically occurs in Southern California when escrow is performed by independent escrow companies. 1. Title and Full Escrow 2. Title and Subescrow 3. Title Only 4. Full Escrow Only 5. Subescrow Only 6. None of the Above
UTC01.E	Other Services	Report one of the following codes. Other services refer to services or products other than a preliminary report, title policy, full escrow or subescrow. 1. Other Services Provided 2. Other Services Not Provided

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC01.F	Work Charge/Premium Split	Pursuant to Insurance Code § 12412, an underwritten title company may divide fees or charges, for work and services actually performed, between title insurance companies or between title insurance companies and underwritten title companies. A work charge or premium split refers to a payment from the reporting company to another underwritten title company or to a title insurer or a payment to the reporting company from another title insurance company or underwritten title company. Some companies refer to work charges as premium splits because the company collecting the title premium or escrow fee pays a portion of the premium or escrow fee to another company for services provided in connection with the title or escrow transaction. Work charges/premium splits refer only to payments between title insurance companies, between underwritten title companies or between underwritten title companies and title insurers. Report one of the following codes: 1. Paid a work charge to another title insurance company, underwritten title company or controlled escrow company 2. Received a work charge from another title insurance company, underwritten title company or controlled escrow company 3. Paid a work charge and received work charge from another title insurance company, underwritten title company or controlled escrow company 4. No work charge paid or received
UTC01.G	Type of Real Estate Transaction	Report one of the following codes: 1. Residential Sale — New Home 2. Residential Sale — Resale of Existing Home 3. Residential Sale — Land Only 4. Residential Refinance 5. Residential Home Equity 6. Commercial or Industrial Sale 7. Commercial or Industrial Refinance 8. Other
UTC01.H	Street Address of Property	Report the street address of the property that is the subject of the transaction.
UTC01.I	ZIP Code of Property	Report the 5–Digit ZIP Code location of the property that is the subject of the transaction as XXXXX.
UTC01.J	County of Property	Report the county location of the property that is the subject of the transaction.
UTC01.K	Source of Order	Report the name of the source of the title and/or escrow order. The source of the title order is the entity referring the business to the underwritten title company. The source of the title order may not be the reporting company itself. If the source of business is the escrow department of the reporting company, report the escrow department's source of business. Report the complete name of any real estate agent, real estate agency, lender, homebuilder or other business source. Report the business name of the source, if one exists.
UTC01.L	Affiliated Source	Report 1 if the source of business is affiliated with the reporting company or 0 if the source of business is not affiliated with the reporting company.
UTC01.M	Date Order Opened	Report the date the order was opened in YYYYMMDD format.
UTC01.N	Date Order Cancelled	If the order was cancelled, report the date cancelled in YYYYMMDD format.
UTC01.O	Date Order Closed	If the order was closed, report the date closed in YYYYMMDD format
UTC01.P	Type of Title Transaction	Report one of the following codes: 1. Concurrent Issue of Single Owner's Policy and Single Lender's Policy 2. Concurrent Issue of Multiple Owner's Policies and Single Lender's Policy 3. Concurrent Issue of Single Owner's Policy and Multiple Lender's Policies 4. Concurrent Issue of Multiple Owner's Policies and Multiple Lenders' Policies 5. Single Owner's Policy Only 6. Single Lender's Policy Only 7. Multiple Owners' Policies Only 8. Multiple Lender's Policies Only 9. Title Guaranty 10. Other Title Transaction
UTC01.Q	Preliminary Report Delivered	Report one of the following codes: 1. Preliminary report delivered with no charge 2. Preliminary report delivered with a charge 3. Preliminary report prepared but not delivered 4. No preliminary report prepared.
UTC01.R	Preliminary Report Charge	If a separate charge was made for the preliminary report, report the amount received for the preliminary report to the nearest dollar without commas, periods or dollar signs.
UTC01.S	Title Premium Owner's Policy	If an owner's policy was issued, report the premium charge for the policy to the nearest dollar without commas, periods or dollar signs. If multiple owners' policies were issued, report the total premium charge for all owners' policies.
UTC01.T	*Title Premium Lender's Policy*	If a lender's policy was issued, report the premium charge for the policy to the nearest dollar without commas, periods or dollar signs. If multiple lenders' policies were issued, report the total premium charge for all lenders' policies.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC01.U	Escrow Charge	If a charge was made for setting up, conducting or canceling full escrow, report the amount of the charge to the nearest dollar without commas, periods or dollar signs.
UTC01.V	Subescrow Charge	If a charge was made for setting up, conducting or canceling subescrow, report the amount of the charge to the nearest dollar without commas, periods or dollar signs.
UTC01.W	Other Services Charges	If a charge was made for other services, report the total amount of the charges to the nearest dollar without commas, periods or dollar signs.
UTC01.X	Title Search/Examination Location	Report the code from UTC09 for the name and location of the facility where the title search and examination was conducted. This data field must have an entry if the entry in UTC01.D is 1, 2 or 3.
UTC01.Y	Title Policy Issuance Location	Report the code from UTC09 for the name and location of the facility where the title policy was produced and issued from. This data field must have an entry if there is an entry in UTC01.S or UTC01.T.
UTC01.Z	Escrow Office	Report the code from UTC09 for the name and location of the facility where the escrow was carried out. This data field must have an entry if the entry in UTC01.D is 1, 2, 4 or 5.
UTC01.AA	Independent Escrow Company	If the transaction involved escrow services performed by an entity other than the reporting company, report the name of that entity. If the transaction did not involve escrow services provided by an entity other than the reporting company, leave blank.
UTC01.AB	Independent Escrow Company Affiliation	If there is an entry in UTC01.AA, report 1 if the entity is affiliated with the reporting company. Refer to Insurance Code Section 1215(a) for the definition of "affiliate" and "affiliated." If there is no entry in UTC01.AA, leave blank.

(b) UTC02 California and Countrywide Balance Sheet. Report UTC02 is a report of assets and liabilities for underwritten title companies on a consolidated Generally Accepted Accounting Principles (GAAP) basis. Preparation of Report UTC02 requires consolidation of countrywide financial results of subsidiaries, conversion of countrywide consolidated financial results to a GAAP basis, allocation of countrywide financial results to individual states and summarization of individual states' financial results. An underwritten title company that operates only in California will make entries only in the California–specific data columns.

(1) A single Report UTC02 shall be submitted for an underwritten title company and any of its subsidiaries which are engaged in the business of title insurance, including:

- title insurance companies;
- underwritten title companies; and
- controlled escrow companies.

(2) An underwritten title company licensed in California that is a subsidiary of another title insurance company or an underwritten title company licensed in California shall not submit Report UTC02, but have its experience included in the report of the parent. There shall be only one submission for a parent underwritten title company and all its subsidiaries engaged in the business of title insurance. Any underwritten title company which is not submitting a Report UTC02 because that company's experience has been consolidated into a parent company's submission shall indicate on its (the subsidiary's) individual submission transmittal form the name of the parent company which has submitted a Report UTC02 or Report TI02 which includes the experience of the subsidiary reporting company.

(3) Two or more title insurance companies — which are not subsidiaries of one another but are affiliated with one another because they are all subsidiaries of a parent holding company which is not a title insurance company, underwritten title company or controlled escrow company — must each submit a consolidated Report UTC02 for the experience of the reporting company and any subsidiaries that are title insurance companies, underwritten title companies or controlled escrow companies.

(4) Report UTC02 must be submitted using the spreadsheet template provided by the Commissioner on the Department of Insurance web site: www. insurance. ca.gov.

(5) Report UTC02 includes two sections — assets/liabilities and adjustments. In the adjustments section, reporting companies shall report the consolidation and GAAP conversion adjustments made to individual statutory accounting reports for the business entities engaged in the business of title insurance in California.

(6) For most asset and liability items, the reporting company may choose the allocation method to assign the portion of those countrywide asset or liability amounts not identifiable with a specific state to California that best reflects amount of the asset or liability used to support the business of title insurance in California. The allocation of the following liability items is prescribed:

(A) Incurred But Not Reported Title Reserves: Allocate to California by the ratio of the sum of California–specific incurred title losses and California–specific title case loss reserves at the end of the reporting year to the sum of countrywide incurred title losses and countrywide title case loss reserves at the end of the reporting year.

(B) GAAP Net Worth: Allocate to California by the ratio of the sum of California reserves and California total revenue at the end of the reporting year to the sum of countrywide reserves plus total revenue at the end of the reporting year. Reserves are the sum of title case loss reserves, title incurred but not reported reserves and escrow loss reserves. Total revenue is the sum of gross title premium, escrow fees, subescrow fees and other services charges which are Lines UTC03.01, UTC03.04, UTC03.05 and UTC03.08, respectively, of Report UTC03.

(7) Report UTC02 requests experience for the current reporting year and the prior reporting year. For example, the 2008 UTC02 report, submitted by April 30, 2009, contains assets and liabilities at year–end 2009 (the current reporting year) and at year–end 2008 (the prior reporting year).

(8) Reporting companies shall maintain any worksheets used in preparing Report UTC02 for the six most recent reporting years.

(9) Data Fields for Section 1: Assets and Liabilities

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC02.A	Name of Reporting Entity	Report the name of the reporting company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report UTC02.
UTC02.B	Line #	Report the line number from the table in section 2356.9(b)(10) to indicate the asset or liability being adjusted or consolidated.
UTC02.C	Line Description	Report the line description, corresponding to the line number in UTC02.B.
UTC02.D	California Current Year Total	Report the sum of columns UTC02.I and UTC02.P for this line. This is a calculated amount in the spreadsheet template.
UTC02.E	California Prior Year Total	Report the sum of columns UTC02.K and UTC02.S for this line. This is a calculated amount in the spreadsheet template.
UTC02.F	Elsewhere Current Year Total	Report the sum of UTC02.H less UTC02.D. This is a calculated amount in the spreadsheet template.
UTC02.G	Elsewhere Prior Year Total	Report the sum of UTC02.J less UTC02.E. This is a calculated amount in the spreadsheet template.
UTC02.H	Countrywide Consolidated Current Year Total	Report the consolidated GAAP–basis countrywide total for the current year for the asset or liability item in UTC02.D. This amount comes from the consolidation worksheets.
UTC02.I	Countrywide Consolidated Prior Year Total	Report the consolidated GAAP–basis countrywide total for the prior year for the asset or liability item in UTC02.D. This amount comes from the consolidation worksheets.
UTC02.J	California Identifiable Current Year	Report the amount of the asset or liability item in UTC02.D that is identifiable with California–only business for the current year. Report only the amounts for items exclusively associated with California–only business. The current year is the most recent experience period. This amount comes from the allocation worksheets.
UTC02.K	California Identifiable Prior Year	Report the amount of the asset or liability item in UTC02.D that is identifiable with California–only business for the prior year. Report only the amounts for items exclusively associated with California–only business. The prior year is the most recent experience period prior to the current year. This amount comes from the allocation worksheets.
UTC02.L	Elsewhere Identifiable Current Year	Report the amount of the asset or liability item in UTC02.D that is identifiable with individual states other than California for the current year. Report only those amounts for items exclusively associated with individual states other than California. This amount comes from the allocation worksheets.
UTC02.M	Elsewhere Identifiable Prior Year	Report the amount of the asset or liability item in UTC02.D that is identifiable with individual states other than California for the prior. Report only those amounts for items exclusively associated with individual states other than California. The prior year is the most recent experience period prior to the current year. This amount comes from the allocation worksheets.
UTC02.N	Countrywide Non–Identifiable Current Year Basis for	Report the amount UTC02.H less the sum of UTC02.J and UTC02.L. This is a calculated amount in the spreadsheet template.
UTC02.O	Allocation of Current Year Non–Identifiable	Report the basis for determining the share of the amount reported in UTC02.N associated with California business. Stated differently, report the method of allocating a portion of the amount in UTC02.N to California business. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
UTC02.P	California Allocation of Countrywide Non–Identifiable Current Year	Report the amount of item UTC02.N allocated to California business using the method described in UTC02.O for the current year.
UTC02.Q	Countrywide Non–Identifiable Prior Year	Report the amount UTC02.I less the sum of UTC02.K and UTC02.M. This is a calculated amount in the spreadsheet template.
UTC02.R	Basis for Allocation of Prior Year Non–Identifiable	Report the basis for determining the share of the amount reported in UTC02.Q associated with California business for the prior year. Stated differently, report the method of allocating a portion of the amount in UTC02.Q to California business for the prior year. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
UTC02.S	California Allocation of Countrywide Non–Identifiable *Prior Year*	Report the amount of item UTC02.Q allocated to California business using the method described in UTC02.R for the prior year.

(10) Data Rows for Section 1: Assets and Liabilities

The report of assets and liabilities shall be prepared according to Generally Accepted Accounting Principles (GAAP).

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC02.01	Assets: Cash and Cash Equivalents	Report consolidated and allocated GAAP amounts.
UTC02.02	Assets: Accounts Receivable Net of Allowance for Doubtful Accounts	Report consolidated and allocated GAAP amounts.
UTC02.03	Assets: Notes/Loans Receivable	Report consolidated and allocated GAAP amounts.
UTC02.04	Assets: Prepaid Expenses	Report consolidated and allocated GAAP amounts.
UTC02.05	Assets: Deferred Income Taxes	Report consolidated and allocated GAAP amounts.
UTC02.06	Assets: Investments	Report consolidated and allocated GAAP amounts.
UTC02.07	Assets: Property and Equipment Net of Depreciation	Report consolidated and allocated GAAP amounts.
UTC02.08	Assets: Escrow Statutory Deposits with Insurance Commissioner	Report consolidated and allocated GAAP amounts.
UTC02.09	Assets: Goodwill/Costs in Excess of Assets Acquired	Report consolidated and allocated GAAP amounts.
UTC02.10	Assets: Title Plant	Report consolidated and allocated GAAP amounts.
UTC02.11	Assets: Aggregate Write-Ins for Assets	This is a calculated amount and no entry is required in the spreadsheet template. This entry is carried from the list of write-ins for assets.
UTC02.12	Assets: Total	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines UTC02.01 through UTC02.11.
UTC02.13	Liabilities: Accounts Payable and Accrued Expenses	Report consolidated and allocated GAAP amounts.
UTC02.14	Liabilities: Title Premium Due Others	Report consolidated and allocated GAAP amounts.
UTC02.15	Liabilities: Notes/Loans Payable	Report consolidated and allocated GAAP amounts.
UTC02.16	Liabilities: Leases Payable	Report consolidated and allocated GAAP amounts.
UTC02.17	Liabilities: Accrued Personnel Costs — Salary, Bonus and Vacation Payable	Report consolidated and allocated GAAP amounts.
UTC02.18	Liabilities: Pensions and Retirement Plans	Report consolidated and allocated GAAP amounts.
UTC02.19	Liabilities: Title Case Loss Reserves	Report consolidated and allocated GAAP amounts.
UTC02.20	Liabilities: Title Incurred But Not Reported Loss Reserves	Report consolidated and allocated GAAP amounts. Allocate to California by the ratio of the sum of California-specific incurred title losses and California-specific title case loss reserves at the end of the reporting year to the sum of countrywide incurred title losses and countrywide title case loss reserves at the end of the reporting year.
UTC02.21	Liabilities: Escrow Claim Reserves	Report consolidated and allocated GAAP amounts.
UTC02.22	Liabilities: Total Reserves	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines UTC02.19 through UTC02.21.
UTC02.23	Liabilities: Aggregate Write-Ins for Liabilities	This is a calculated amount and no entry is required in the spreadsheet template. This entry is carried from the list of write-ins for liabilities.
UTC02.24	Liabilities: Total	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines UTC02.13 through UTC02.21 and UTC02.23.
UTC02.25	Equity: Stock	Report consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
UTC02.26	Equity: Additional Paid-In Capital	Report consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
UTC02.27	Equity: Retained Earnings	Report consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.
UTC02.28	Equity: Aggregate Write-Ins for Equity	Report consolidated GAAP amounts only in countrywide amount columns. Only total equity is allocated to California.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC02.29	Equity: Total	This is a calculated amount for countrywide amount columns and no entry is required in the spreadsheet template. This entry is the sum of lines UTC02.25 through UTC02.28. For California amount columns, allocate to California by the ratio of the sum of California reserves and California total revenue at the end of the reporting year to the sum of countrywide reserves plus total revenue at the end of the reporting year.
UTC02.30	Liabilities and Equity: Total	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines UTC02.24 and UTC02.29.

(11) Data Fields for Section 2: Adjustments for Consolidation and GAAP Conversion

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC02.AA	Name of Reporting Entity	Report the name of the insurer group or holding company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report UTC02
UTC02.AB	Line #	Report the line number from the table in section 2356.9(b)(10) to indicate the asset or liability item being adjusted or consolidated.
UTC02.AC	Line Description	Report one of the following codes: 1. Consolidation Adjustment 2. GAAP Conversion Adjustment
UTC02.AD	Reporting Period	Report one of the following codes: 1. Current Year 2. Prior Year
UTC02.AE	Parent Company	If entry in UTC02.AC is 1 (consolidation adjustment), report the complete name of the parent company.
UTC02.AF	Subsidiary Company	If entry in UTC02.AC is 1 (consolidation adjustment), report the complete name of the subsidiary company.
UTC02.AG	Amount of Adjustment	Report the amount of the consolidation or GAAP conversion adjustment.
UTC02.AH	Description of Adjustment	Provide a description of the consolidation or GAAP conversion adjustment in sufficient detail to enable a person familiar with SAP and GAAP accounting to understand the exact adjustment made. The spreadsheet template can accept detailed explanations.

(c) UTC03 California and Countrywide Income Statement. Report UTC03 is a report of income and expenses for title insurance companies on a consolidated Generally Accepted Accounting Principles (GAAP) basis. Preparation of Report UTC03 requires consolidation of countrywide financial results of subsidiaries, conversion of countrywide consolidated financial results to a GAAP basis, allocation of countrywide financial results to individual states and summarization of individual states' financial results. An underwritten title company that operates only in California will make entries only in the California–specific data columns.

(1) A single Report UTC03 shall be submitted for an underwritten title company and any of its subsidiaries which are engaged in the business of title insurance, including:

- title insurance companies;
- underwritten title companies; and
- controlled escrow companies.

(2) An underwritten title company licensed in California that is a subsidiary of another title insurance company or an underwritten title company licensed in California shall not submit Report UTC03, but have its experience included in the report of the parent. Stated differently, there shall be only one submission for a parent underwritten title company and all its subsidiaries engaged in the business of title insurance. Any underwritten title company which is not submitting a Report UTC03 because that company's experience has been consolidated into a parent company's submission shall simply indicate on its (the subsidiary's) individual submission transmittal form the name of the parent company which has submitted a Report UTC03 which includes the experience of the subsidiary reporting company.

(3) Two or more underwritten title companies — which are not subsidiaries of one another but are affiliated with one another because they are all subsidiaries of a parent holding company which is not a title insurance company, underwritten title company or controlled escrow company — must each submit a consolidated Report UTC03 for the experience of the reporting company and any subsidiary title insurance companies, underwritten title companies or controlled escrow companies.

(4) Report UTC03 must be submitted using the spreadsheet template provided by the Commissioner on the Department of Insurance web site: www. insurance. ca.gov.

(5) Report UTC03 includes two sections — income/expenses and adjustments. In the adjustments section, reporting companies shall report the consolidation and GAAP conversion adjustments made to individual statutory accounting reports for the business entities engaged in the business of title insurance in California.

(6) Report UTC03 requests experience for the current reporting year and the prior reporting year. For example, the 2009 UTC03 report, submitted by April 30, 2010, contains revenue and expenses for the calendar year 2009 (the current reporting year) and for the calendar year 2008 (the prior reporting year).

(7) For most expense items, the reporting company may choose the allocation method to assign the portion of those countrywide expense amounts that are not identifiable with a specific state to California that best reflects the amount of the expense used to support the business of title insurance in California. The allocation of the following expense items is prescribed:

(A) Unallocated Title Loss Adjustment Expense:

Allocate to California by the ratio of the sum of California–specific incurred title losses and incurred title allocated loss adjustment expense to the sum of countrywide incurred title losses and incurred title allocated loss adjustment expenses. Allocated loss adjustment expenses are claim settlement expenses that are solely associated with a specific title claim. Unallocated loss adjustment expenses are other claim settlement expenses which are not solely associated with a specific title claim.

(B) Unallocated Escrow Loss Adjustment Expense:

Allocate to California by the ratio of the sum of California–specific incurred escrow losses and incurred escrow allocated loss adjustment expense to the sum of countrywide incurred escrow losses and incurred es-

crow allocated loss adjustment expenses. Allocated loss adjustment expenses are claim settlement expenses that are solely associated with a specific escrow claim. Unallocated loss adjustment expenses are other claim settlement expenses which are not solely associated with a specific escrow claim.

(8) Reporting companies shall maintain any worksheets used in preparing Report UTC03 for the five most recent reporting years.

(9) Report UTC03 includes some expense categories that may be pass–through items on a real estate transaction closing statement, where pass–through means that the amount for a particular item by a party to the transaction is the exact amount received by a service provider other than the reporting company. Reporting companies shall not include pass–through items in reported income or expenses.

(10) UTC03 Data Fields for Section 1: Income and Expenses

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC03.A	Name of Reporting Entity	Report the name of the underwritten title company. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC03 report of the underwritten title company. The California and Countrywide Balance Sheet for such a controlled escrow company reports shall be completed using the UTC03report format.
UTC03.B	Line #	Report the line number from the table in section 3256.9(c)(11) to indicate the income or expense item being adjusted or consolidated.
UTC03.C	Line Description	Report the line description, corresponding to the line number in UTC03.B.
UTC03.D	California Current Year Total	Report the sum of columns UTC03.I and UTC03.P for this line. This is a calculated amount in the spreadsheet template.
UTC03.E	California Prior Year Total	Report the sum of columns UTC03.K and UTC03.S for this line. This is a calculated amount in the spreadsheet template.
UTC03.F	Elsewhere Current Year Total	Report the sum of UTC03.H less UTC03.D. This is a calculated amount in the spreadsheet template.
UTC03.G	Elsewhere Prior Year Total	Report the sum of UTC03.J less UTC03.E. This is a calculated amount in the spreadsheet template.
UTC03.H	Countrywide Current Year Total	Report the consolidated GAAP–basis countrywide total for the current year for the income or expense item in UTC03.D.
UTC03.I	Countrywide Prior Year Total	Report the consolidated GAAP–basis countrywide total for the prior year for the income or expense item in UTC03.D.
UTC03.J	California Identifiable Current Year	Report the amount of the income or expense item in UTC03.D that is identifiable with California–only business for the current year. Report only the amounts for items exclusively associated with California–only business. The current year is the most recent experience period.
UTC03.K	California Identifiable Prior Year	Report the amount of the income or expense item in UTC03.D that is identifiable with California–only business for the prior year. Report only the amounts for items exclusively associated with California–only business. The prior year is the most recent experience period prior to the current year.
UTC03.L	Elsewhere Identifiable Current Year	Report the amount of the income or expense item in UTC03.D that is identifiable with individual states other than California for the current year. Report only those amounts for items exclusively associated with individual states other than California.
UTC03.M	Elsewhere Identifiable Prior Year	Report the amount of the income or expense item in UTC03.D that is identifiable with individual states other than California for the prior. Report only those amounts for items exclusively associated with individual states other than California. The prior year is the most recent experience period prior to the current year.
UTC03.N	Countrywide Non–Identifiable Current Year	Report the amount UTC03.H less the sum of UTC03.J and UTC03.L. This is a calculated amount in the spreadsheet template.
UTC03.O	Basis for Allocation of Current Year Non–Identifiable	Report the basis for determining the share of the amount reported in UTC03.N associated with California business. Stated differently, report the method of allocating a portion of the amount in UTC03.N to California business. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened
UTC03.P	California Allocation of Countrywide Non–Identifiable Current Year	Report the amount of item UTC03.N allocated to California business using the method described in UTC03.O for the current year.
UTC03.Q	Countrywide Non–Identifiable Prior Year	Report the amount UTC03.I less the sum of UTC03.K and UTC03.M. This is a calculated amount in the spreadsheet template.
UTC03.R	Basis for Allocation of Prior Year	Non–IdentifiableReport the basis for determining the share of the amount reported in UTC03.Q associated with California business for the prior year. Stated differently, report the method of allocating a portion of the amount in UTC03.Q to California business for the prior year. Examples include: Number of title policies closed Number of employees Number of claims Number of escrow orders opened

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC03.S	California Allocation of Countrywide Non-Identifiable Prior Year	Report the amount of item UTC02.Q allocated to California business using the method described in UTC02.R for the prior year.

(11) Data Rows for Section 1: Income and Expenses

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC03.01	Gross Written Title Premium	Report total gross title premium before remittances to underwritten title companies during the reporting period. Report direct business, meaning before adjustments for reinsurance. Include direct business, meaning business performed by the reporting company without the use of an underwritten title company. Report the entire gross premium and do not deduct any amounts incurred for work charges/premium splits or add any amounts received for work charges/premium splits. Report premium only for transactions in which the reporting company was the initial recipient of funds from the ultimate consumer. If a work charge/premium split is involved, only one reporting company shall report the gross title premium.
UTC03.02	Work Charges Incurred for Title	Pursuant to Insurance Code § 12412, an underwritten title company may divide fees or charges, for work and services actually performed, between underwritten title companies or between title insurance companies and underwritten title companies. A work charge or premium split refers to a payment from the reporting company to another underwritten title company or to a title insurer or a payment to the reporting company from another underwritten title company or a title insurer for work performed on title or escrow. Some companies refer to work charges as premium splits because the company collecting the title premium or escrow fee pays a portion of the premium or escrow fee to another company for services provided in connection with the title or escrow transaction. Work charges/premium splits refer only to payments between underwritten title companies or between underwritten title companies and title insurers. See the instructions for report UTC05 for additional explanation of work charges/premium splits. In Line UTC03.02, report only work charges incurred for title-related work during the reporting period.
UTC03.03	Work Charges Received for Title	In Line UTC03.03, report only work charges received for title-related work during the reporting period. See the instructions for Line UTC03.02 for an explanation of work charges/premium splits.
UTC03.04	Escrow Fees	Report total fees for full escrow during the reporting period. Report sub-escrow in line UTC03.05. Report other service charges for escrow-related activity in line UTC03.08. Report the entire escrow fee and do not deduct any amounts incurred for work charges/fee splits or add any amounts received for work charges/fee splits. Report escrow fees only for transactions in which the reporting company was the initial recipient of funds from the ultimate consumer. If a work charge/fee split is involved, only one reporting company shall report the escrow fee.
UTC03.05	Subescrow Fees	Subescrow refers to funds transfer for lenders in those situations where an entity other than the reporting company is performing other escrow activities. Subescrow typically occurs in Southern California when escrow is performed by independent escrow companies. Report only those revenues in Line UTC03.05 associated with a separate and identifiable charge for subescrow activities during the reporting period, whether those activities are called subescrow or something else, such as title payoff.
UTC03.06	Work Charges Incurred for Escrow	In Line UTC03.06, report only work charges incurred for escrow-related work during the reporting period. See the instructions for Line UTC03.02 for an explanation of work charges/premium splits.
UTC03.07	Work Charges Received for Escrow	In Line UTC03.07, report only work charges received for escrow-related work during the reporting period. See the instructions for Line UTC03.02 for an explanation of work charges/premium splits.
UTC03.08	Other Service Charges	Report the amount of revenue from other service charges other than subescrow during the reporting period. Report subescrow on Line UTC03.05
UTC03.09	Revenue from Other Licensees	Report the amount of any revenue received from other licensees for services provided to those licensees, other than amounts received for work charges. Licensees are title insurance companies, underwritten title companies and controlled escrow companies licensed to conduct the business of title insurance in California. Include, for example, revenue received for title plant subscription fees, title search packages or production services. Report revenue from work charges in UTC03.03 and UTC03.07.
UTC03.10	Aggregate Write-Ins for Other Operating Revenues	This amount is carried from the detailed write-in table below the income statement. Report any other types and amounts of operating revenue not included in lines UTC03. 01 through UTC03.09 during the reporting period.
UTC03.11	Total Operating Revenues	This amount is calculated and no entry is required in the spreadsheet template. This entry is the sum of Lines UTC03.1 through UTC03.10 during the reporting period.
UTC03.12	Title Premium Retained by or Remitted to Underwritten Title Companies.	Report the amount of title premium from line UTC03.01 that was retained by or remitted to underwritten title companies pursuant to underwriting agreements during the reporting period.
UTC03.13	*Personnel: Salaries*	Report the amount of salaries for employees during the reporting period. This amount is carried from Table UTC04 for the appropriate reporting period.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC03.14	Personnel: Commission	Report the amount of commissions for employees during the reporting period. This amount is carried from Table UTC04 for the appropriate reporting period.
UTC03.15	Personnel: Bonus	Report the amount of bonuses for employees during the reporting period. This amount is carried from Table UTC04 for the appropriate reporting period.
UTC03.16	Personnel: Payroll Taxes	Report the amount of payroll taxes for employees during the reporting period. This amount is carried from Table UTC04 for the appropriate reporting period.
UTC03.17	Personnel: Employee Benefits	Report the amount of employee benefits for employees during the reporting period. Benefits include pension contributions, health insurance, life insurance, workers' compensation insurance, food for employees, gatherings and entertainment for employees and employee training. Report payroll taxes in Line UTC03.16. Report expense allowances and reimbursements for sales personnel in UTC03.57. This amount is carried from Table UTC04 for the appropriate reporting period.
UTC03.18	Personnel: Temporary Agency Expenses	Report the amount for temporary agencies for personnel during the reporting period. This amount is carried from Table UTC04 for the appropriate reporting period.
UTC03.19	Personnel: Contract Workers/Consultants	Report the amount for contract workers and consultants during the reporting period. Do not include amounts for legal or accounting services. Report these amounts in lines UTC03.60 and UTC03.58, respectively. This amount is carried from Table UTC04 for the appropriate reporting period.
UTC03.20	Personnel: Aggregate Write-Ins for Personnel Expenses	This amount is carried from the detailed write-ins for personnel expenses and no entry in the spreadsheet template is required for this line. Report any other types and amounts of personnel expenses not included in lines UTC03.13 through UTC03.19 during the reporting period in the detailed write-in table.
UTC03.21	Total Personnel Expenses	This amount is calculated and no entry is required in the spreadsheet template. This entry is the sum of Lines UTC03.13 through UTC03.20 during the reporting period.
UTC03.22	Title Losses Paid	Report the amount of title losses paid, net of recoveries from subrogation or errors and omissions insurance policies, during the reporting period.
UTC03.23	RESERVED	Leave Blank
UTC03.24	RESERVED	Leave Blank
UTC03.25	Change in Title Loss Reserves	Report the change in title reserves during the reporting period, including case reserves and incurred but not reported (IBNR) reserves.
UTC03.26	Title Loss Adjustment Expenses	Report the amount incurred for title loss adjustment expense, net of recoveries from subrogation or errors and omissions insurance policies, during the reporting period.
UTC03.27	Total Title Loss and Loss Settlement Expenses	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines UTC03.22 through UTC03.26.
UTC03.28	Escrow Losses Paid	Report the amount of escrow losses paid, net of recoveries from subrogation or errors and omissions insurance polices, during the reporting period.
UTC03.29	Change in Escrow Loss Reserves	Report the change in escrow loss reserves during the reporting period.
UTC03.30	Escrow Loss Adjustment Expenses	Report the amount incurred for escrow loss adjustment expenses, net of recoveries from subrogation or errors and omissions insurance policies, during the reporting period.
UTC03.31	Total Escrow Loss and Loss Settlement Expenses	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of lines UTC03.28 through UTC03.31.
UTC03.32	Title Plant Maintenance for Owned Title Plants	Report the amount for maintaining owned title plants during the reporting period. Do not include subscription fees or rent for non-owned plants, which is reported in Line UTC03.33. Do not include amounts for customer service information, which is reported in Line UTC03.50. Do not include amounts received from other licensees for title plant access as an offset to amounts incurred by the reporting company. Report any such amounts in UTC03.09.
UTC03.33	Subscription Fees, Rent and Charges for Non-Owned Title Plants	Report the amount for subscription fees, rent and other charges for non-owned title plants during the reporting period. Do not include amounts for customer service information, which is reported in Line UTC03.50. Include only those amounts spent for title search, examination and underwriting activities. Do not include amounts received from other licensees for title plant access and use as an offset to amounts incurred by the reporting company. Report any such amounts in UTC03.09.
UTC03.34	Title Search/Examination and Underwriting	Report any non-personnel expenses associated with title search, examination and underwriting not otherwise reported in UTC03.32 and UTC03.33. Include amounts for third-party title search and examination reports.
UTC03.35	Preliminary Report Production and Issuance	Report any non-personnel expenses associated with the production and issuance of preliminary reports, other than expenses for title plant and search, examination and underwriting.
UTC03.36	Title Policy Issuance and Maintenance	Report any non-personnel expenses associated with the issuance of title policy, including creation of the physical title insurance policy and maintenance of information regarding the title insurance policy. Do not include expenses reported in lines UTC03.32 through UTC03.35.
UTC03.37	Funds Transfer	Report any non-personnel expenses associated with the transfer of funds from and to parties to the real estate transaction.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC03.38	Notary Fees	Report the amount for notary fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
UTC03.39	Conveyancing Fees	Report the amount for conveyancing fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
UTC03.40	Inspection Fees	Report the amount for inspection fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
UTC03.41	Tax Service Contract Fees	Report the amount for tax service contract fees during the reporting period. Do not report any amount passed through without mark–up as a separate charge to the consumer.
UTC03.42	Recording Fees and Costs	Report the amount for non–personnel recording fee expenses. Include amounts for third party recording services during the reporting period. Pass–through items — fees collected from and paid for by the consumer without mark–up — shall not be included as expenses or revenues.
UTC03.43	Messenger, Overnight and Delivery Service — Preliminary Reports	Report the amount for messenger, overnight and delivery service for preliminary reports and preliminary report–related materials during the reporting period. Do not include postage and freight costs, which are reported in Line UTC03.57.
UTC03.44	Messenger, Overnight and Delivery Service — Title Policies	Report the amount for messenger, overnight and delivery service for title policies during the reporting period. Do not include postage and freight costs, which are reported in Line UTC03.57.
UTC03.45	Messenger, Overnight and Delivery Service — Escrow	Report the amount for messenger, overnight and delivery service for escrow and escrow–related materials during the reporting period. Do not include postage and freight costs, which are reported in Line UTC03.57.
UTC03.46	Messenger, Overnight and Delivery Service — Other	Report the amount for messenger, overnight and delivery service other than reported in UTC03.43, UTC03.44 and UTC03.45 and excluding any messenger and delivery expenses associated with sales, marketing or customer service, which are reported in Lines UTC03.48, UTC03.49 and UTC03.50, respectively. Do not include postage and freight costs, which are reported in Line UTC03.57.
UTC03.47	Sales Expenses: Reimbursements/ Allowances for Sales Personnel	Report the amount reimbursed to sales personnel for sales and customer service expenses during the reporting period. Include allowances and reimbursements for travel expenses, such as allowance for auto or entertainment.
UTC03.48	Sales Expenses: Other	Report the amount of sales expenses other than reported in Lines UTC03.47 and UTC03.49 during the reporting period. Include sales–related travel expenses not otherwise reported in Line UTC03.47. Include amounts incurred for company–provided autos for sales personnel.
UTC03.49	Business Promotion, Advertising and Public Relations	Report the amount of expenses for business promotion, advertising, and public relations during the reporting period. Do not include amounts otherwise reported in Lines UTC03.47 and UTC03.48.
UTC03.50	Customer Service	Report the amount of expenses for customer service, including, for example and not limited to, amounts incurred for information provided to real estate agent and brokers unrelated to specific title or escrow transactions during the reporting period.
UTC03.51	Travel and Travel Items Other Than Sales, Marketing and Customer Service	Report the amount of expenses for travel and travel items, other than sales, marketing and customer service–related travel included in Lines UTC03.47 through UTC03.50, respectively, during the reporting period.
UTC03.52	Facility Rent, Depreciation and Amortization	Report the amount of expenses for building rent for facilities used for the business of title insurance during the reporting period, net of any rental income received for those facilities. Report rent incurred for equipment in Line UTC03.53. Report rental income from investment properties — facilities not used for the business of title insurance — as investment income in Line UTC03.78. Include depreciation and amortization for facilities used in the business of title insurance.
UTC03.53	Equipment Rent	Report the amount of expenses for renting or leasing equipment.
UTC03.54	Data Processing Services and Software	Report the amount of expenses for data processing services and software. Do not include any expenses for software related to title plant access or subscription, which is reported in UTC03.33. Do not include expenses for software or data processing for sales, marketing or customer service, which are reported in Lines UTC03.48, UTC03.49 and UTC03.50, respectively.
UTC03.55	Printing/Stationery/Supplies	Report the amount of expenses for printing, stationery and supplies during the reporting period excluding any printing, stationery or supplies associated with sales, marketing or customer service, which are reported in Lines UTC03.48, UTC03.49 and UTC03.50, respectively.
UTC03.56	Telephone/Utilities	Report the amount for telephone and utilities during the reporting period, other than telephone expense reimbursements to sales personnel, which must be reported in Line UTC03.47 and other than telephone or utilities associated with sales, marketing or customer service, which are reported in Lines UTC03.48, UTC03.49 and UTC03.50, respectively.
UTC03.57	Postage and Freight	Report the amount of expense for postage and freight during the reporting period excluding any postage and freight associated with sales, marketing or customer service, which are reported in Lines UTC03.48, UTC03.49 and UTC03.50, respectively.
UTC03.58	Accounting/Auditor Fees	Report the amount of expenses for outside auditors and accounting services during the reporting period.
UTC03.59	Director Fees	Report the amount for fees to members of the company's Board of Directors during the reporting period.

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC03.60	Legal Fees	Report the amount for outside legal services, other than claim–related legal services during the reporting period. Report claim–related legal services in Lines UTC03.26 and UTC03.30.
UTC03.61	Management Fees	Report the amount for management services during the reporting period. Do not include amounts paid to individuals. Report amounts to individuals in Line UTC03.19.
UTC03.62	Licenses, Fees, Taxes Other Than Income and Premium	Report the amount for licenses, regulatory fees and taxes during the reporting period. Do not include state or federal income taxes, which are reported in Lines UTC03.85 and UTC03.86, respectively. Do not include premium taxes which are reported in Line UTC03.63. Include property taxes only for real estate and buildings employed for the business of title insurance.
UTC03.63	Premium Taxes	Report the amount of premium taxes during the reporting period.
UTC03.64	Depreciation/Amortization Other Than Real Estate and Buildings	Report the amount of expenses for depreciation and amortization during the reporting period other than depreciation and amortization of real estate and buildings.
UTC03.65	Bad Debt Expense	Report the amount of expenses for collecting overdue debt or for writing off bad debt during the reporting period.
UTC03.66	Insurance	Report the amount for all types of insurance during the reporting period, other than insurance provided on behalf of employees, which is reported in Line UTC03.17.
UTC03.67	Lobbying	Report the amount for lobbying activities during the reporting period, including amounts paid to trade associations for lobbying activities. Report amounts to trade associations for activities other than lobbying in Line UTC03.69.
UTC03.68	Donations	Report the amount of donations during the reporting period.
UTC03.69	Trade Associations and Advisory Organizations	Report the amount for trade associations and advisory organizations during the reporting period.
UTC03.70	Dues/Subscriptions Other than Trade and Advisory Organizations	Report the amount for dues and subscriptions other than dues and subscriptions to trade associations and advisory organizations during the reporting period
UTC03.71	Fines or Penalties	Report the amount for fines, penalties and restitution to regulatory agencies, courts or to consumers pursuant to regulatory or judicial decisions or settlements during the reporting period.
UTC03.72	Aggregate Write–Ins for Other Expenses	This amount is carried from the detailed write–in table below the income statement and no entry in the spreadsheet template is required for this line. Report any other types and amounts of operating expenses, not included in Lines UTC03.22 through UTC03.71 during the reporting period in the detailed write–in table.
UTC03.73	Total Operating Expenses	This amount is calculated and no entry is required. This entry is the sum of lines UTC03.22 through UTC03.72.
UTC03.74	Net Operating Income	This amount is calculated and no entry is required. This entry is Line UTC03.11 less the sum of Lines TI.03.12, UTC03.21 and UTC03.73.
UTC03.75	Interest Paid	Report amount for interest on loans during the reporting period.
UTC03.76	Investment Income — Tax Exempt	Report tax–exempt investment income before investment expenses during the reporting period.
UTC03.77	Investment Income — Dividends	Report dividend investment income before investment expenses during the reporting period.
UTC03.78	Investment Income — Other	Report investment income other than tax–exempt and dividend investment income before investment expenses during the reporting period. Include rental income from real estate facilities not used for the business of title insurance.
UTC03.79	Investment Expenses	Report expenses associated with investment income items. Report this entry as a negative for amounts incurred.
UTC03.80	Net Investment Income	This is a calculated amount and no entry in the spreadsheet template is required. This entry is the sum of lines UTC03.76 through UTC03.78 less line UTC03.79.
UTC03.81	Realized Capital Gains	Report realized capital gains during the reporting period.
UTC03.82	Unrealized Capital Gains	Report unrealized capital gains during the reporting period.
UTC03.83	Aggregate Write–Ins for Other Operating Expenses	This amount is carried from the detailed write–ins for other operating expenses.
UTC03.84	Net Income Before Income Taxes	This amount is calculated and no entry is required in the spreadsheet template. This entry is Line UTC03.74 less Line UTC03.75 plus the sum of Lines UTC03.80 through UTC03.83.
UTC03.85	Provision for State Income Taxes	Report the amount of the provision for state income taxes during the reporting period.
UTC03.86	Provision for Federal Income Taxes	Report the amount of the provision for federal income taxes during the reporting period.
UTC03.87	Net Income After Taxes	This amount is calculated and no entry is required in the spreadsheet template. This entry is Line UTC03.84 less Lines UTC03.85 and UTC03.86.

(12) Data Fields for Section 2: Adjustments for Consolidation and GAAP Conversion

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC03.AA	Name of Reporting Company	Report the name of the reporting company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report UTC03
UTC03.AB	Line #	Report the line number from the table in section 2356.9(c)(11) to indicate the income or expense item being adjusted or consolidated.
UTC03.AC	Line Description	Report one of the following codes: 1. Consolidation Adjustment 2. GAAP Conversion Adjustment
UTC03.AD	Reporting Period	Report one of the following codes: 1. Current Year 2. Prior Year
UTC03.AE	Parent Company	If entry in UTC03.AC is 1 (consolidation adjustment), report the complete name of the parent company.
UTC03.AF	Subsidiary Company	If entry in UTC03.AC is 1 (consolidation adjustment), report the complete name of the subsidiary company.
UTC03.AG	Amount of Adjustment	Report the amount of the consolidation or GAAP conversion adjustment.
UTC03.AH	Description of Adjustment	Provide a description of the consolidation or GAAP conversion adjustment in sufficient detail to enable a person familiar with SAP and GAAP accounting to understand the exact adjustment made. The spreadsheet template can accept detailed explanations.

(d) UTC04 Detailed California Personnel Expense Report. Report UTC04 is a report of personnel count and expenses on a consolidated Generally Accepted Accounting Principles (GAAP) basis. A single Report UTC04 shall be submitted for an underwritten title company and any of its subsidiaries which are engaged in the business of title insurance, including:

- title insurance companies;
- underwritten title companies; and
- controlled escrow companies.

(1) An underwritten title company licensed in California that is a subsidiary of another underwritten title company or an underwritten title company licensed in California shall not submit Report UTC04, but have its experience included in the report of the parent. Stated differently, there shall be only one submission for a parent underwritten title company and all its subsidiaries engaged in the business of title insurance. Any underwritten title company which is not submitting a Report UTC04 because that company's experience has been consolidated into a parent company's submission shall simply indicate on its (the subsidiary's) individual submission transmittal form the name of the parent company which has submitted a Report UTC04 which includes the experience of the subsidiary reporting company.

(2) Two or more title insurance companies — which are not subsidiaries of one another but are affiliated with one another because they are all subsidiaries of a parent holding company which is not a title insurance company, underwritten title company or controlled escrow company — must each submit a consolidated Report UTC04 for the experience of the reporting company and any subsidiary title insurance companies, underwritten title companies or controlled escrow companies.

(3) For personnel who work on California business and business elsewhere, report only that portion of the workers' time and personnel expenses associated with California–only business. Retain worksheets of worker time and expense allocations to California and to activity codes for the five most recent reporting years.

(4) Report UTC04 must be submitted using the spreadsheet template provided by the Commissioner on the Department of Insurance web site: www.insurance.ca.gov.

(5) This report can be visualized as a table with each row reflecting a record of personnel expenses for a specific activity. The activity categories to be used in this report are shown in the table below. The columns of the table are data fields, described further below, which provide detail on the personnel expenses for a specific activity.

(6) Activity Codes

Assign personnel expenses to the activities described in the table. Assign a specific personnel expense only once to a single activity code.

Row/Line Number/ Activity Codes	*Name of Data Line*	*Description of Data Line*
UTC04.01	Title Search/Examination	This activity includes acquisition of title and related documents from a title plant or other information source, examination and analysis of the documents and underwriting. Include administrative and support staff associated with title search, examination and underwriting activities.
UTC04.02	Title Plant Maintenance	This activity includes physical maintenance of a back plant and physical maintenance and updates to the current plant. This activity includes maintenance of databases and information for title and title–related documents. Include administrative and support staff associated with title plant maintenance activities.
UTC04.03	Preliminary Report Issuance	This activity includes preparation and issuance of the preliminary report. This activity does not include title search, examination or underwriting, but is limited to preparation and issuance of the preliminary report after the title search, examination and underwriting have been completed. Include administrative and support staff associated with preliminary report issuance activities.
UTC04.04	Title Policy Issuance and Maintenance	This activity includes preparation and issuance of the title policy and related documents and maintenance of customer information. This activity does not include title search, examination or underwriting, but is limited to preparation and issuance of the title policy after the title search, examination and underwriting have been completed. Include administrative and support staff associated with title policy issuance and maintenance activities.
UTC04.05	*Title Claims*	This activity includes intake, processing and settling of title insurance claims. Include administrative and support staff title claims activities.

Row/Line Number/ Activity Codes	*Name of Data Line*	*Description of Data Line*
UTC04.06	General Management	This activity includes general management of the underwritten title company. Do not include managers of activities specifically identified in this list. Those managers shall be included with the functional activity they manage. For example, include a general counsel in this category, but do not include a lawyer dedicated to settling claims. Include human resources in the category. Include general information technology in this category — computer and network installation, maintenance and support not otherwise assigned to a separate functional category. Include any personnel devoted to developing and maintaining hardware and software for electronic access to title plant information in the Title Plant Maintenance category.
UTC04.07	Customer Support	This activity includes answering questions and providing information to the underwritten title company's customers or members of the public, outside of formal title search and examination and claims settlement activities. Include administrative and support staff associated with customer service activities.
UTC04.08	Sales	This activity includes sales, business promotion and solicitation. Include administrative and support staff associated with sales activities.
UTC04.09	Escrow Document Production and Execution	This activity code includes the main activities related to escrow including preparation and execution of instruction and documents. Include administrative and support staff associated with escrow document production activities. Include personnel engaged in all escrow activities under this code other than: escrow–related general management (UTC04.06) escrow–related customer service (UTC04.07) escrow–related sales (UTC04.08) escrow claims (UTC04.10) recording of documents (UTC04.11) courier and delivery — escrow (UTC04.14) funds transfer (UTC04.16)
UTC04.10	Escrow Claims Settlement	This activity includes processing and settling escrow claims. Include administrative and support staff associated with escrow claims settlement activities.
UTC04.11	Recording of Documents	This activity includes the recording of documents as required by the transaction. Include administrative and support staff associated with recording of document activities.
UTC04.12	Courier and Delivery — Preliminary Reports	This activity includes courier and delivery for preliminary reports and preliminary report–related materials. Include administrative and support staff associated with preliminary report–related courier and delivery activities.
UTC04.13	Courier and Delivery — Title Policies	This activity includes courier and delivery for title policies. Include administrative and support staff associated with title policy–related courier and delivery activities.
UTC04.14	Courier and Delivery — Escrow	This activity includes courier and delivery for escrow and escrow–related materials. Include administrative and support staff associated with escrow–related courier and delivery activities.
UTC04.15	Courier and Delivery — Other	This activity includes any courier and delivery personnel not included in UTC04.12, UTC04.13 or UTC04.14. Include administrative and support staff associated with other courier and delivery activities.
UTC04.16	Funds Transfer	This activity includes activities specifically related to funds transfer. Include administrative and support staff associated with funds transfer activities.
UTC04.17	Other Services	This activity includes any service for which a charge is made and which is not a title policy, preliminary report, full escrow or subescrow. Include administrative and support staff associated with other services activities.
UTC04.18	Other	If none of the above categories can be used, use this code and explain the activity. If there are two or more types of "Other" activities, use codes 18, 19 and 20 as necessary.

(7) Include all employees, temporary/contract workers and consultants in the following reporting format. If a worker is engaged in two or more of the categories listed, estimate the percentage of the worker's time in each of the categories and allocate the worker's personnel costs on the basis of the time percentages. Assign administrative and other support workers to the category or categories for which the workers provide the support.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC04.A	Name of Title Insurer	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC04 report of the underwritten title company. The Detailed California Personnel Expense Report for such a controlled escrow company reports shall be completed using the UTC04 report format.
UTC04.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC04.C	Activity Category	These codes for activity categories are already entered in the spreadsheet template.
UTC04.D	Description of Activity Category	If UTC04.C is a code for "Other," provide a name that describes the additional activity category. For activity codes UTC04.01 through UTC04.14, the description is already entered into the spreadsheet template.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC04.E	Total Full–Time Equivalent Workers	Report the total number of full–time equivalent employees, temporary/contract workers and consultants for this category during the reporting period. An employee who is engaged in each of two activity categories for 50% of her time would be a 0.5 full–time equivalent in each activity category. An employee who worked in one activity for only three months of the year would be a 0.25 full–time equivalent.
UTC04.F	Salary	Report the aggregate salary incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for that individual worker by multiplying the total salary incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E.
UTC04.G	Payroll Taxes	Report the aggregate payroll taxes incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for that individual worker by multiplying the total salary incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E.
UTC04.H	Commission	Report the aggregate commission incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for that individual worker by multiplying the total commission incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E.
UTC04.I	Bonus	Report the aggregate bonuses incurred for this activity during the reporting period. If a worker engaged in more than one activity, calculate the amount for individual workers by multiplying the total bonus incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E. Include in the bonus category any amounts incurred as dividends to owners who are also employees of, or independent contractors to, the company.
UTC04.J	Employee Relations and Welfare	Report the aggregate benefits incurred to workers for this activity during the reporting period. Include pension contributions, health insurance, life insurance, employee training and education, food for employees and gatherings and entertainment for employees. Do not include expense allowances and reimbursements for sales personnel, which are reported in UTC03. If a worker was engaged in more than one activity, calculate the amount for individual workers by multiplying the total benefits incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E.
UTC04.K	Temporary Agency Workers	Report the aggregate amount paid to temporary worker agencies for personnel for this activity during the reporting period. If a worker was engaged in more than one activity, calculate the amount for individual workers by multiplying the total benefits incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E.
UTC04.L	Consultants/Contract Workers	Report the aggregate benefits incurred to workers for this activity during the reporting period. Do not include amounts paid for legal or accounting services, which are reported in UTC03.60 and UTC03.58, respectively. If a worker was engaged in more than one activity, calculate the amount for individual workers by multiplying the total benefits incurred for this individual for the year by the fraction of his/her time worked in this category that was used to calculate the amount reported in UTC04.E.
UTC04.M	Total Personnel Costs	Report the row sum for columns UTC04. Carry these totals to the personnel expense lines in Report UTC03.

(e) UTC05 Detailed Escrow Report. Each underwritten title company shall submit this report of escrow activity performed by the underwritten title company during the reporting period. Each underwritten title company shall also submit a report UTC05 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC05 of the underwritten title company.

(1) Report only full escrow transactions. Do not report subescrow or escrow–related other services in Report UTC05.

(2) If the reporting company provides different types of full escrow service — for example, a basic full escrow and an enhanced full escrow with some additional services included — report the escrow in Report UTC05 as the basic escrow plus a surcharge. Using our example, the surcharge would be the increment in cost above the basic full escrow service and the surcharge name would be "enhanced full escrow package." In addition, report the different types of full escrow services as surcharges in Report UTC11.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC05.A	Name of Reporting Entity	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC05 report of the underwritten title company. The Detailed Escrow Report for such a controlled escrow company reports shall be completed using the UTC05 report format.
UTC05.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC05.C	Internal Transaction #	Report the internal transaction # from UTC01.C for which the escrow activity is associated.
UTC05.D	Number of Parties	Report the number of parties involved in the escrow.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC05.E	Amount of Escrow	Report the total amount of the escrow. This is the value used to determine the escrow charge.
UTC05.F	Basic Escrow Charge	Report the basic escrow charge to the nearest dollar without commas, periods or dollar signs. The basic escrow charge is the escrow charge before any discounts or surcharges
UTC05.G	Discount/Surcharge 1	If a discount or surcharge was applied, report the code from Report UTC11 for the discount or surcharge applied.
UTC05.H	Discount/Surcharge 2	If more than one discount or surcharge was applied, report the code from Report UTC11 of the second discount or surcharge applied.
UTC05.I	Discount/Surcharge 3	If more than two discounts or surcharges were applied, report the code from Report UTC11 of the third discount or surcharge applied.
UTC05.J	Discount/Surcharge 4	If more than three discounts or surcharges were applied, report the code from Report UTC11 of the fourth discount or surcharge applied.
UTC05.K	Discount/Surcharge 5	If more than four discounts or surcharges were applied, report the code from Report UTC11 of the fifth discount or surcharge applied.
UTC05.L	Total Escrow Charge	Report the total escrow charge after all discounts and surcharges.

(f) UTC06 Report of Work Charges/Premium Splits Activity. Each underwritten title company shall submit this report of work charges/premium splits for title, escrow and other services activity by the underwritten title company during the reporting period. Each underwritten title company shall also submit a report UTC06 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC05 of the underwritten title company.

(1) Pursuant to Insurance Code Section 12412, an underwritten title company may divide fees or charges, for work and services actually performed, between title insurance companies or between title insurance companies and underwritten title companies. A work charge or premium split refers to a payment from the reporting company to another underwritten title company or to a title insurer or a payment to the reporting company from another underwritten title company or underwritten title company that represents a split of the premium for division of work. Some companies refer to work charges as premium splits because the company collecting the title premium or escrow fee pays a portion of the premium or escrow fee to another company for services provided in connection with the title or escrow transaction. Work charges/premium splits refer only to payments between title insurance companies, between underwritten title companies or between underwritten title companies and title insurers and are further limited to transactions that reflect a split of the title premium or escrow charge. See the instructions for UTC07 for discussion of fees paid to or received from other title insurance companies, underwritten title companies or controlled escrow companies for services received or provided and how these types of fees differ from work charges/ premium splits.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC06.A	Name of Reporting Entity	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC06 report of the underwritten title company. The Report of Work Charges/Premium Splits Activity for such a controlled escrow company reports shall be completed using the UTC05 report format.
UTC06.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC06.C	Internal Transaction #	Report the internal transaction # from UTC01.C for which the work charge information is associated.
UTC06.D	Work Charge Paid or Received	Report one of the following codes: 1. Work charge PAID for title services only. 2. Work charge PAID for escrow services only. 3. Work charge PAID for title and escrow services. 4. Work charge RECEIVED for title services only. 5. Work charge RECEIVED for escrow services only. 6. Work charge RECEIVED for title and escrow services. 7. Work charge PAID and RECEIVED for title services only. 8. Work charge PAID and RECEIVED for escrow services only. 9. Work charge PAID and RECEIVED for title and escrow services.
UTC06.E	Description of Title Services	Describe the specific title services provided in exchange for the work charge/premium split.
UTC06.F	Description of Escrow Services	Describe the specific escrow services provided in exchange for the work charge/premium split.

(g) UTC07 Report of Amounts Received from and Paid to Other Licensees and Affiliates. Each underwritten title company shall submit this report of amounts received from and paid to other licensees and affiliated companies for title, escrow and other services activity by the underwritten title company during the reporting period. Each underwritten title company shall submit a report UTC07 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC07 of the underwritten title company.

(1) This report is a description of activities, other than work charge/premium split activities, for which the reporting company received a payment for providing a service to another underwritten title company, underwritten title company or controlled escrow company or made a payment to another underwritten title company, underwritten title company or controlled escrow company for a service provided by the other entity. This report also includes payments to or received from affiliates, even if the affiliate is not a title insurance company, underwritten title company or controlled escrow company licensed to do business in California.

(2) Although work charge/premium split activities are a form of service provided by one licensee to another for a payment, work charge/premium split activity is not included in Report UTC07. The distinction be-

tween work charges/premium split and the payments reported in this table is that work charges/premium split represent a division of premium or charges for a division of work on a specific title or escrow transaction while the activities in this report represent activities for which payment is not tied to the revenue of a specific transaction. Stated differently, this report is a description of expenses paid or revenues received by the reporting company which are not associated with a specific title or escrow order. For the company receiving the service, the activity reflects an expense item. In contrast, a work charge/premium split reflects a reduction of premium, or revenue, for the service received.

(3) There shall be a separate record for each type of service provided or received and for each entity to whom the service was provided or from whom the service was received. For example, if the reporting company provided the same service to two underwritten title companies, there shall be two records for that activity — one for each company to whom the service was provided.

(4) This report can be visualized as a table with each row or record as a summary of information about a specific type of other service and with each column a different data field. The instructions below explain the entries in each data field or column.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC07.A	Name of Reporting Entity	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC07 report of the underwritten title company. The Report of Amounts Received from and Paid to Other Licensees for such a controlled escrow company reports shall be completed using the UTC07 report format.
UTC07.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC07.C	Name of Entity Paid or from Which Payment Was Received	Report the name of the underwritten title company, underwritten title company or controlled escrow company to which a payment was made for services provided by that entity or from whom a payment was received for services provided to that entity. There shall be a separate record for each type of service provided or received and for each entity to whom the service was provided or from whom the service was received. For example, if the reporting company provided the same service to two underwritten title companies, there shall be two records for that activity — one for each company to whom the service was provided. Do not include work charges/premium splits in this report. Work charges/premium splits are reported in UTC06. A work charge represents a division of the title premium or escrow fee for the division of work to perform title or escrow. This table is a report of expenses and revenues for services provided outside of the premium split arrangement.
UTC07.D	Affiliated, Non–Affiliated and Licensee	Report one of the following codes to describe the type of entity named in UTC07.C: 1. Affiliated title insurance company, underwritten title company or controlled escrow company licensed to do business in California. 2. Affiliated company other than a title insurance company, underwritten title company or controlled escrow company licensed to do business in California. 3. Non–affiliated title insurance company, underwritten title company or controlled escrow company licensed to do business in California.
UTC07.E	Expense or Revenue	Report one of the following codes: 1 if the reporting company paid for a service. 2 if the reporting company received revenue for a service.
UTC07.F	Description of Activity	Describe the service provided with moderate detail. "Title Search" or "Escrow" or "Management Services" are insufficient descriptions.
UTC07.G	Category	If the item is an expense — the entry in UTC07.E is 1 — report the line from Report UTC03 in which the item is reported for non–personnel expenses and the line from Report UTC04 in which the items is reported for personnel expenses. If the item is revenue — the entry in UTC07.E is 2 — report the line from Report UTC03 in which the revenue is reported.
UTC07.H	Amount Paid	If the entry in data field UTC07.E is 1, report to the nearest dollar the total amount paid for the activity in data field UTC07.F provided to the entity in data field UTC07.C during the reporting period. If the entry in data field UTC07.D is 2, report to the nearest dollar the total amount received for the activity in data field UTC07.E from the entity in data field UTC07. C during the reporting period.
UTC07.I	Special Nature of Affiliate	Enter 1 if the affiliate in this transaction received a benefit from a lending institution where the benefit was derived from the lending institution's absorption of expenses incident to providing a normal banking function or the lending institution's forbearance from charging a fee in connection with providing a normal banking function. Otherwise, leave blank.

(h) UTC08 Report of Other Services Activity. Each underwritten title company shall submit this report of other services activity during the reporting period. Each underwritten title company shall submit a report UTC08 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC08 of the underwritten title company.

(1) Other services include any activity for which a charge is made to one of the parties in the real estate transaction and which is not the production or delivery of a preliminary report, the production or delivery of a title insurance policy, the provision of full escrow or the provision of subescrow.

(2) This report can be visualized as a table with each row or record as a summary of information about a specific type of other service and with each column a different data field. The instructions below explain the entries in each data field or column.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC08.A	Name of Reporting Entity	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC08 report of the underwritten title company. The Report of Other Services Activity for such a controlled escrow company shall be completed using the UTC08 report format.
UTC08.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC08.C	Internal Transaction #	Report the internal transaction # from UTC01.C for which the other service charge activity is associated. If the other services are associated with a transaction not reported in table UTC01, create a new and unique transaction number for use with this report.
UTC08.D	Other Service	Report the name of the other service provided. Other services include any service for which a charge is made and which is not the provision of a preliminary report, a title policy, full escrow or subescrow. Report a separate record for each other service provided. For example, if three other services were provided in connection with a particular transaction number, there will be three records, all of which have the same transaction number in line UTC08.C. If four other services were provided in connection with a particular transaction #, there will be four records with the same transaction # in UTC08.C
UTC08.E	Other Service Category	Report one of the following codes to describe the other service: 1. Preliminary Report–related 2. Title Policy Issuance–related 3. Escrow–related 4. Other
UTC08.F	Other Service Charge	Report the amount of the charge for the other service described in line UTC08.D.
UTC08.G	Other Service Charge Date of Rate Filing	Report the submission date of the rate filing in which the other service charge is listed in YYYYMMDD format where YYYY is the year, MM is the month and DD is the day.
UTC08.H	Filing Page Number	Report the page number of the rate filing from field UTC08.G on which the charge for the other service from field UTC08.D can be found.

(i) UTC09 Report of Facilities Locations. Each underwritten title company shall submit this report of facilities locations employed by the underwritten title company for California–related title, escrow and other services activities. Each underwritten title company shall submit a report UTC09 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC09 of the underwritten title company.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC09.A	Name of Reporting Entity	Report the name of the underwritten title company whose facilities are reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose facilities are not otherwise included in the UTC09 report of the underwritten title company. The Report of Facilities Locations for such a controlled escrow company reports shall be completed using the UTC09 report format.
UTC09.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC09.C	Office Code	Report a unique numerical code of up to five digits for each office location of the reporting entity. Office refers to any location in which the business of title insurance is transacted and includes locations where title plants are housed, where title search and examination is conducted, where title policies are produced and issued from, where escrow is conducted, where other services are performed and where any aspect of the business of title insurance is conducted. Report the numerical code without comma or leading zeroes. Report a separate record for each office location.
UTC09.D	Office Street Address	Report the street address of the office whose code is reported in field UTC09.C.
UTC09.E	Office City	Report the city location of the office whose code is reported in field UTC09.C.
UTC09.F	Office State	Report the state location of the office whose code is reported in field UTC09.B. Report the United States Post Office two–letter state abbreviation in capital letters.
UTC09.G	Office 5 Digit ZIP	Report the 5–digit ZIP Code location of the office whose code is reported in field UTC09.C. Report the 5 digits without commas and use a leading zero when appropriate.
UTC09.H	Office Plus 4 ZIP	Report the Plus–4 ZIP Code location of the office whose code is reported in field UTC09.B.
UTC09.I	Foreign Location	If the office location is outside of the United States, report the city, state or province, and country location of the office whose code is reported in field UTC09.C.
UTC09.J	Location Activity: Title Search and Examination	Report the average number of full–time equivalent workers engaged in title search, examination and underwriting at this location during the reporting period.
UTC09.K	Location Activity: Title Plant	Report the average number of full–time equivalent workers engaged in title plant maintenance at this location during the reporting period.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC09.L	Location Activity: Preliminary Report Production and Issuance	Report the average number of full–time equivalent workers engaged in preliminary report production and issuance activities — not title plant maintenance or title search, examination or underwriting — at this location during the reporting period.
UTC09.M	Location Activity: Title Policy Production and Issuance	Report the average number of full–time equivalent workers engaged in title policy production and issuance at this location during reporting period. Do not include workers engaged in title plant maintenance, title search, examination and underwriting or preliminary report production and issuance.
UTC09.N	Location Activity: Escrow Closing	Report the average number of full–time equivalent workers engaged in escrow closing activities at this location during the reporting period.
UTC09.O	Location Activity: Escrow Other Than Closing	Report the average number of full–time equivalent workers engaged in escrow activities other than escrow closing at this location during the reporting period.

(j) UTC10 Report of Title Premium by Underwritten Title Company. Each underwritten title company shall submit this report of title insurance premium going to title insurance companies pursuant to underwriting agreements during the reporting period. This report can be visualized as a table with each row (record) describing the title insurance premium generated by a single underwritten title company and each column representing the data fields described below.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC10.A	Name of Reporting Entity	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company.
UTC10.B	Reporting Year	Report the calendar year experience period as a four–digit numeral.
UTC10.C	Name of Title Insurance Company	Report the name of the title insurance company to whom a portion of the title insurance premium was paid.
UTC10.D	Gross Title Premium	Report the total amount of title premium during the reporting period for policies issued through the title insurance company listed in data field UTC10.C.
UTC10.E	Amount to Title Insurance Company	Report the total amount of the title premium from data field UTC10.D that went to the title insurance company listed in data field UTC10.C.
UTC10.F	Amount to Reporting Company	Report the total amount of the title premium from data field UTC10.D that went to the reporting company.

(k) UTC11 Report of Escrow Discounts and Surcharges. Each underwritten title company shall submit this report of escrow discounts and surcharges used during the reporting period. Each underwritten title company shall submit a report UTC11 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC11 of the underwritten title company.

(1) This report can be visualized as a table with each row (record) describing a different title policy form endorsement and each column representing the data fields described below.

(2) Rates for different geographic locations shall be reported as discounts and surcharges of a base escrow rate.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC11.A	Name of Reporting Entity	Report the name of the underwritten title company whose experience is being reported. A separate report is required for each underwritten title company. A separate report is required for each controlled escrow company which is controlled by the underwritten title company and whose experience is not otherwise included in the UTC11 report of the underwritten title company. The Report of Escrow Discounts and Surcharges for such a controlled escrow company reports shall be completed using the UTC11 report format.
UTC11.B	Reporting Year	Report the calendar year experience period as a four–digit number.
UTC11.C	Code	Report a unique code for each escrow discount and surcharge.
UTC11.D	Name	Report a description of the discount or surcharge associated with the unique code from field UTC11.C.
UTC11.F	Type of Rate	Describe the type of rate by entering one of the following codes: 1 if the rate is a percentage of an amount in a basic rate table 2 if the rate is a fixed dollar amount 3 if the rate is a percentage of the basic premium or 4 if other than 1, 2 or 3.
UTC11.G	Rate	If the code in UTC15.F is 1, report the percentage as a whole number. For example, if the rate is 64% of the basic rate table, report 64. If the code in UTC15.F is 2, report the dollar amount to the nearest whole dollar without commas. If the code in UTC15.F is 3, report the percentage as a whole number. If the code in UTC15.F is 4, report a description of the rate.

(*l*) UTC12 Six–Year Report of Selected Data. Each underwritten title company submitting Reports UTC02 and UTC03 shall submit this report of six years of experience for certain line items from Reports UTC02 and UTC03. Report UTC12, like Reports UTC02 and UTC03, is a report of consolidated GAAP–basis experience. Report UTC12 must be reported using a spreadsheet template provided by the Commissioner on the Department's web site: www.insurance.ca.gov.

Field/Column Number	*Name of Data Field*	*Description and Instructions for Data Field*
UTC12.A	Name of Reporting Company	Report the name of the reporting company. In a separate document accompanying the submission of this report, provide a list of the entities whose experience is consolidated into Report UTC02.
UTC12.B	Current Reporting Year — California	Report experience for the current — most recent — reporting period in this column for California–only business in this column. The entries in this column are carried from Table UTC02, Column UTC02.D and Table UTC03, Column UTC03.D for line items in those reports that match the line items in this report.
UTC12.C	First Prior Year — California	Report experience for the first reporting period prior to the current reporting period for California–only business in this column. The entries in this column are carried from Table UTC02, Column UTC02.E and Table UTC03, Column UTC03.E for line items in those reports that match the line items in this report.
UTC12.D	Second Prior Year — California	Report experience for the second reporting period prior to the current reporting period for California–only in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period.
UTC12.E	Third Prior Year — California	Report experience for the third reporting period prior to the current reporting period for California–only in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period.
UTC12.F	Fourth Prior Year — California	Report experience for the fourth reporting period prior to the current reporting period for California–only business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period.
UTC12.G	Fifth Prior Year — California	Report experience for the fifth reporting period prior to the current reporting period for California–only business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets and liabilities employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period. No expense item row entries are required for this reporting period (column).
UTC12.H	Current Year — Countrywide	Report consolidated GAAP–basis experience for the current — most recent — reporting period for countrywide business in this column. The entries in this column are carried from Table UTC02, Column UTC02.H and Table UTC03, Column UTC03.H for line items in those reports that match the line items in this report.
UTC12.I	First Prior Year — Countrywide	Report consolidated GAAP–basis experience for the first reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are carried from Table UTC02, Column UTC02.I and Table UTC03, Column UTC03.I for line items in those reports that match the line items in this report.
UTC12.J	Second Prior Year — Countrywide	Report consolidated GAAP–basis experience for the second reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period.
UTC12.K	Third Prior Year — Countrywide	Report consolidated GAAP–basis experience for the third reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period.
UTC12.L	Fourth Prior Year — Countrywide	Report consolidated GAAP–basis experience for the fourth reporting period prior to the current reporting period for countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets, liabilities and expenses employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period.
UTC12.M	Fifth Prior Year — Countrywide	Report consolidated GAAP–basis experience for the fifth reporting period prior to the current reporting period for total countrywide business in this column. The entries in this column are not carried from other tables and must be calculated using the same procedures employed in Table UTC02 and Table UTC03. Stated differently, the same procedures used to allocate assets and liabilities employed in Table UTC02 and Table UTC03 must be used to develop the entries for this earlier period. No expense item row entries are required for this reporting period (column).

Row/Line Number	*Name of Data Line*	*Description and Instructions for Data Line*
UTC12.01	Year	Enter the year corresponding to the reporting year for each column as a four digit number without commas. For example, if the current reporting period is 2010, enter 2010 in this row in Column UTC12.B and 2009, 2008, 2007 and 2006 in Columns UTC12.C, UTC12.D, UTC12.E and UTC12.F. In this example, enter 2010, 2009, 2008, 2007 and 2006 in Columns UTC12.G, UTC12.H, UTC12.I, UTC12.J and UTC12.K, respectively.
UTC12.02	Gross Title Premium	Report gross title premium in the same manner as reported in TI03.01.
UTC12.03	Escrow Fees	Report full escrow fees in the same manner as reported in TI03.04.
UTC12.04	Subescrow Fees	Report subescrow fees in the same manner as reported in TI03.05
UTC12.05	Other Service Charges	Report other service revenues in the same manner as reported in TI03.08
UTC12.06	Total Operating Revenue	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of rows UTC12.02 through UTC12.05. Report total operating revenue including title insurance premiums, escrow fees, other service charges and other operating revenue during the reporting period.
UTC12.07	Total Title Loss and Loss Settlement Expenses	Report title loss and loss settlement expenses in the same manner as reported in TI03.27, which is the sum of title losses paid, changes in title loss case reserves and title loss adjustment expenses.
UTC12.08	Total Escrow Loss and Loss Settlement Expenses	Report escrow loss and loss settlement expenses in the same manner as reported in TI03.31, which is the sum of escrow losses paid, changes in escrow loss reserves and escrow loss adjustment expenses.
UTC12.09	Net Investment Income	Report net investment income in the same manner as reported in TI03.79.
UTC12.10	Realized Capital Gains	Report realized capital gains in the same manner as reported in TI03.80.
UTC12.11	Unrealized Capital Gains	Report unrealized realized capital gains in the same manner as reported in TI03.80.
UTC12.12	Net Income Before Taxes	Report net income before taxes in the same manner as reported in TI03.83
UTC12.13	State Income Tax	Report state income taxes in the same manner as reported in TI03.84.
UTC12.14	Federal Income Tax	Report federal income taxes in the same manner as reported in TI03.85.
UTC12.15	RESERVED	Leave Blank
UTC12.16	Goodwill	Report goodwill in the same manner as reported in TI02.09
UTC12.17	RESERVED	Leave Blank
UTC12.18	Total Assets	Report total assets in the same manner as reported in TI02.12
UTC12.19	Title Case Loss Reserves	Report title case loss reserves in the same manner as reported in TI02.19.
UTC12.20	Title Incurred But Not Reported Loss Reserves	Report title incurred but not reported loss reserves in the same manner as reported in TI02.20.
UTC12.21	Escrow Claim Reserves	Report escrow claim reserves in the same manner as reported in TI02.21.
UTC12.22	Total Reserves	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of UTC12.19, UTC12.20 and UTC12.21.
UTC12.23	RESERVED	Leave Blank
UTC12.24	Total Liabilities	Report total liabilities in the same manner as reported in TI02.24.
UTC12.25	RESERVED	Leave Blank
UTC12.26	Total Equity	Report total equity in the same manner as reported in TI02.29
UTC12.27	Total Reserves and Equity	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of UTC12.22 and UTC12.26.
UTC12.28	Total Liabilities and Equity	This is a calculated amount and no entry is required in the spreadsheet template. This entry is the sum of UTC12.24 and UTC12.26.

(m) UTC13 Report of Unusual Charges. Each underwritten title company shall submit this report of unusual charges made pursuant to Insurance Code Section 12401.8. Each underwritten title company shall submit a report UTC13 for each controlled escrow company controlled by the underwritten title company and whose experience is not otherwise included in the report UTC13 of the underwritten title company. This report can be visualized as a table where each row is a separate record corresponding to a separate unusual charge and each column is a separate data field.

Field/Column Number	*Name of Data Field*	*Description and Instructions*
UTC13.A	Name of Reporting Company	Enter the full name of the reporting company.
UTC13.B	Reporting Period	Enter the experience year as a four-digit number without commas.
UTC13.C	Transaction #	Enter the transaction number from Report UTC01 that contains this unusual charge.
UTC13.D	Risk or Service	Enter one of the following codes to describe the unusual charge: 1 for unusual risk 2 for unusual charge
UTC13.E	Amount	Enter the dollar amount for the unusual charge with no commas.
UTC13.F	Description	Provide a complete description of the unusual coverage or unusual service provided.
UTC13.G	Cost Justification	Provide a brief cost justification for the unusual charge.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5, 12412 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 1215, 12401.1, 12401.2, 12401.8 and 12412, Insurance Code.

HISTORY

1. New section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

Subarticle 3. Regulation of Rates for Title Insurance

§ 2357.1. Scope.

The provisions of this subarticle apply to every policy of title insurance issued for any residential property.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New subarticle 3 (sections 2357.1-2352.19) and section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.2. Excessive Charges.

(a) No charge for a policy of title insurance may exceed the maximum title insurance charge for that policy, as specified in section 2357.5. Any charge greater than the maximum title insurance charge is conclusively deemed excessive within the meaning of Insurance Code Section 12401.3, subdivision (a). Any charge no greater than the maximum title insurance charge for that policy is conclusively deemed not to be excessive within the meaning of the same statute.

(b) No charge for a preliminary report may exceed the preliminary report charge specified in section 2357.7. Any charge greater than the preliminary report charge specified in section 2357.7 is conclusively deemed excessive within the meaning of Insurance Code Section 12401.3. Any charge no greater than the preliminary report charge is conclusively deemed not to be excessive within the meaning of the same statute.

(c) Nothing in this article shall preclude a charge less than the maximum title insurance charge or preliminary report charge. Companies are free to charge any rate that does not exceed the maximum title insurance charge or preliminary report charge so long as that rate is not inadequate, unfairly discriminatory, or otherwise in violation of the law.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.3. Determination of Title Insurance Totals.

The Commissioner shall, in consultation with the advisory organizations, determine and publish annually the calculated total and corrected total for each of the following quantities. The calculated and corrected totals are produced in the same manner with one exception — the calculated totals are produced with data as reported while the corrected totals are produced with data as corrected by the Commissioner. In the following sections, instructions for producing calculated totals are presented. The corrected totals are produced in the same manner with the exception of using corrected data, instead of reported data, in the calculation.

(a) Total full-time equivalent workers, computed as the sum of

(1) total preliminary report related full-time equivalent workers;

(2) total title insurance policy related full-time equivalent workers;

(3) total escrow related full-time equivalent workers; and

(4) total subescrow related full-time equivalent workers.

(b) Total preliminary report related full-time equivalent workers, computed as the sum of

(1) the sum of Report TI04, lines TI04.01 (Title Search/Examination), TI04.02 (Title Plant Maintenance), TI04.03 (Preliminary Report Issuance) and TI04.12 (Courier and Delivery — Preliminary Reports); Column TI04.E (Total Full-Time Equivalent Workers); and

(2) the sum of Report UTC04, lines UTC04.01 (Title Search/Examination), UTC04.02 (Title Plant Maintenance), UTC04.03 (Preliminary Report Issuance) and UTC04.12 (Courier and Delivery — Preliminary Reports); Column UTC04.E (Total Full-Time Equivalent Workers).

(c) Total title insurance policy related full-time equivalent workers, computed as the sum, for all reporting companies, of

(1) the sum of Report TI04, lines TI04.04 (Title Policy Issuance), TI04.05 (Title Claims) and TI04.13 (Courier and Delivery — Title Policy); Column TI04.E (Total Full-Time Equivalent Workers); and

(2) the sum of Report UTC04, lines UTC04.04 (Title Policy Issuance), UTC04.05 (Title Claims) and UTC04.13 (Courier and Delivery — Title Policy); Column UTC04.E (Total Full-Time Equivalent Workers).

(d) Total escrow related full-time equivalent workers, computed as the sum, for all reporting companies, of

(1) the sum of Report TI04, lines TI04.09 (Escrow Document Production and Execution), TI04.10 (Escrow Claims Settlement), TI04.11 (Recording of Documents), TI04.14 (Courier and Delivery — Escrow) and TI04.16 (Funds Transfer); Column TI04.E (Total Full-Time Equivalent Workers); and

(2) the sum of Report UTC04, lines UTC04.09 (Escrow Document Production and Execution), UTC04.10 (Escrow Claims Settlement), UTC04.11 (Recording of Documents), UTC04.14 (Courier and Delivery — Escrow) and UTC04.16 (Funds Transfer); Column UTC04.E (Total Full-Time Equivalent Workers); less

(3) total subescrow full-time equivalent workers.

(e) Total subescrow related full-time equivalent workers, computed as the product, of

(1) the sum, for all reporting companies, of

(A) the sum of Report TI04, line TI04.16 (Funds Transfer), Column TI04.E (Total Full-Time Equivalent Workers); and

(B) the sum of Report UTC.04, line UTC04.16 (Funds Transfer), Column UTC04.E (Total Full-Time Equivalent Workers);

(2) multiplied by the ratio of

(A) one-tenth of the total subescrow transactions time

(B) to the sum of

(i) total escrow transactions; and

(ii) one-tenth of the total subescrow transactions.

(f) Total revenue, computed as the sum of

(1) total title insurance premium;
(2) total escrow charges;
(3) total subescrow charges; and
(4) total other service revenue.

(g) Total title insurance premium, computed as the sum, for all reporting companies, of Report TI03, Line TI03.01 (Gross Written Title Premium), Column TI03.D (California Current Year).

(h) Total escrow charges, computed as the sum, for all reporting companies, of

(1) Report TI03, Line TI03.04 (Escrow Fees), Column TI03.D (California Current Year); and

(2) Report UTC03, Line UTC03.04 (Escrow Fees), Column UTC03.D (California Current Year).

(i) Total subescrow charges, computed as the sum, for all reporting companies, of

(1) Report TI03, Line TI03.05 (Subescrow Fees), Column TI03.D (California Current Year); and

(2) Report UTC03, Line UTC03.05 (Subescrow Fees), Column UTC03.D (California Current Year).

(j) Total other service revenue, computed as the sum, for all reporting companies, of

(1) Report TI03, Line TI03.08 (Other Services), Column TI03.D (California Current Year); and

(2) Report UTC03, Line UTC03.08 (Other Services), Column UTC03.D (California Current Year).

(k) Total underwritten title company retained title insurance premium, computed as the sum, for all reporting companies, of Report TI03, Line TI03.12 (Title Premium Retained by or remitted to Underwritten Title Companies), Column TI03.D (California Current Year).

(*l*) Total title insurance company retained title insurance premium, computed as the sum, for all reporting companies, of

(1) total title insurance premium, less
(2) total underwritten title company retained title insurance premium.

(m) Total preliminary report related other service revenue, computed as the sum, for all reporting companies, of

(1) Report TI08, Column TI08.F (Other Service Charge) for those records in which the entry in Column TI08.F (Other Service Charge) is 1 (Preliminary Report Related); and

(2) Report UTC08, Column UTC08.F (Other Service Charge) for those records in which the entry in Column UTC08.F (Other Service Charge) is 1 (Preliminary Report Related).

(n) Total title policy issuance related other service revenue, computed as the sum, for all reporting companies, of

(1) Report TI08, Column TI08.F (Other Service Charge) for those records in which the entry in Column TI08.F (Other Service Charge) is 2 (Title Policy Issuance Related); and

(2) Report UTC08, Column UTC08.F (Other Service Charge) for those records in which the entry in Column UTC08.F (Other Service Charge) is 2 (Title Policy Issuance Related).

(o) Total escrow related other service revenue, computed as the sum, for all reporting companies, of

(1) Report TI08, Column TI08.F (Other Service Charge) for those records in which the entry in Column TI08.F (Other Service Charge) is 3 (Escrow Related); and

(2) Report UTC08, Column UTC08.F (Other Service Charge) for those records in which the entry in Column UTC08.F (Other Service Charge) is 3 (Escrow Related).

(p) Total amount of insurance, computed as the sum, for all reporting companies, of Report TI14, all lines (records), Columns TI14.M (Owner's Policy Amount of Premium) and TI14.P (Lender's Policy 1 Amount of Premium) minus the lesser of Column TI14.M (Owner's Policy Amount of Premium) and TI14.P (Lender's Policy 1 Amount of Premium) when the line (record) has an entry in both columns.

(*q*) *Total escrow value, computed as the sum,* for all reporting companies, of

(1) Report TI05, all lines (records), Column TI05.E (Amount of Escrow); and

(2) Report UTC05, all lines (records), Column UTC05.E (Amount of Escrow).

(r) Total number of preliminary report transactions, computed as the sum, for all reporting companies, of

(1) the count of all records in Report TI01 where the entry in column TI01. Q (Preliminary Report Delivered) is 1 (Delivered with no charge), 2 (Delivered with a charge) or 3 (Prepared But Not Delivered) less the count of any such records where the entry in TI01.F (Work Charge/Premium Split) is 2 (Received a work charge); and

(2) the count of all records in Report UTC01 where the entry in column UTC01.Q (Preliminary Report Delivered) is 1 (Delivered with no charge), 2 (Delivered with a charge) or 3 (Prepared But Not Delivered) less the count of any such records where the entry in UTC01.F (Work Charge/Premium Split) is 2 (Received a work charge).

(s) Total number of title insurance transactions, computed as the count of all records, for all reporting companies, in Report TI12.

(t) Total escrow transactions, computed as the sum, for all reporting companies, of

(1) the count of records in Report TI01 in which the entry in Column TI01.D (Type of Title and Escrow Transaction) is either 1 (Title and Escrow) or 4 (Escrow Only) and the entry in Column TI01.M (Date Order Opened) is on or after the first day of the year reported in Column TI01.B (Reporting Year); and

(2) the count of all records in Report UTC01 in which the entry in Column UTC01.D (Type of Title and Escrow Transaction) is either 1 (Title and Escrow) or 4 (Escrow Only) and the entry in Column UTC01.M (Date Order Opened) is on or after the first day of the year reported in Column UTC01.B (Reporting Year).

(u) Total subescrow transactions, computed as the sum, for all reporting companies, of

(1) the count of all records in Report TI01 in which the entry in Column TI01.D (Type of Title and Escrow Transaction) is either 2 (Title and Subescrow) or 5 (Subescrow Only); and

(2) the count of all records in Report UTC01 in which the entry in Column UTC01.D (Type of Title and Escrow Transaction) is either 2 (Title and Subescrow) or 5 (Subescrow Only).

(v) Total title plant maintenance, computed as

(1) the quantity,

(A) the sum, for all reporting companies, of

(i) Report TI03, lines TI03.32 (Title Plant Maintenance for Owned Title Plants) and TI03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plans), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.02 (Title Plant Maintenance), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, lines UTC03.32 (Title Plant Maintenance for Owned Title Plants) and UTC03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plants), Column UTC04.D (California Current Year); and

(iv) Report UTC04, Line UTC04.02 (Title Plant Maintenance), Column UTC03.M (Total Personnel Cost);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.32 (Title Plant Maintenance for Owned Title Plants), TI03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plans) or TI04.02 (Title Plant Maintenance); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.32 (Title Plant Maintenance), UTC03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plans) or TI04.02 (Title Plant Maintenance for Owned Title Plants);

(2) multiplied by the ratio of

(A) total underwritten title company retained title insurance premium

(B) to the sum, for all reporting companies, of

(i) underwritten title company retained title insurance premium; and

(ii) total preliminary report related other service revenue.

(w) Total taxes, licenses, and fees, computed as the sum, for all reporting companies, of

(1) Report TI03, lines TI03.62 (Licenses, Fees, Taxes Other Than Income and Premium), Column TI03.D (California Current Year, Report); and

(2) Report UTC03, lines UTC03.62 (Licenses, Fees, Taxes Other Than Income and Premium), Column UTC03.D (California Current Year).

(x) Total facility rent, computed as

(1) the quantity,

(A) the sum, for all reporting companies, of

(i) Report TI03, lines TI03.52 (Facility Rent, Depreciation and Amortization), Column TI03.D (California Current Year, Report); and

(ii) Report UTC03, lines UTC03.52 (Facility Rent, Depreciation and Amortization), Column UTC03.D (California Current Year);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.52 (Facility Rent); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column TIUTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.52 (Facility Rent);

(2) multiplied by the ratio of

(A) the sum, for all reporting companies, of

(i) total title insurance premium;

(ii) total escrow charges; and

(iii) total subescrow charges;

(B) to total operating revenue for all reporting companies.

(y) Total search, examination and underwriting cost, computed as

(1) the quantity

(A) the sum, for all reporting companies, of

(i) Report TI03, Lines TI03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plants), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.01 (Title Search/Examination), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, Lines UTC03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plants), Column UTC03.D (California Current Year);

(iv) Report UTC04, Line UTC04.01 (Title Search/Examination), Column UTC04.M (Total Personnel Costs);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plants) or TI04.01 (Title Search/Examnation); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column TIUTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.33 (Subscription Fees, Rent and Charges for Non–Owned Title Plants) or UTC04.01 (Title Search/Examination);

(2) multiplied by the ratio of

(A) total underwritten title company retained title insurance premium

(B) to the sum, for all reporting companies, of

(i) total underwritten title company retained title insurance premium; and

(ii) total preliminary report related other service revenue.

(z) Total preliminary report production and delivery cost, computed as

(1) the quantity

(A) the sum, for all reporting companies, of

(i) Report TI03, Lines TI03.35 (Preliminary Report Production and Issuance) and TI03.43 (Messenger, Overnight and Delivery Service — Preliminary Reports), Column TI03.D (California Current Year);

(ii) Report TI04, Lines TI04.03 (Preliminary Report Issuance) and TI04.12 (Courier and Delivery — Preliminary Reports), Column TI04.M (Total Personnel Costs); and

(iii) Report UTC03, Lines UTC03.35 (Preliminary Report Production and Issuance) and UTC03.43 (Messenger, Overnight and Delivery Service — Preliminary Reports), Column UTC03.D (California Current Year);

(iv) Report UTC04, Lines UTC04.03 (Preliminary Report Issuance) and UTC04.12 (Courier and Delivery — Preliminary Reports), Column UTC04.M (Total Personnel Costs);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI04.03 (Preliminary Report Issuance), TI03.43 (Messenger, Overnight and Delivery Service — Preliminary Reports), TI04.03 (Preliminary Report Issuance) or TI04.12 (Courier and Delivery — Preliminary Reports); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column TIUTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC04.03 (Preliminary ReportIssuance), UTC03.43 (Messenger, Overnight and Delivery Service — Preliminary Reports), UTC04.03 (Preliminary Report Issuance) or UTC04.12 (Courier and Delivery — Preliminary Reports);

(2) multiplied by the ratio of

(A) total underwritten title company retained title insurance premium

(B) to the sum, for all reporting companies, of

(i) underwritten title company retained title insurance premium; and

(ii) total preliminary report related other service revenue.

(aa) Total overhead, computed as

(1) the sum, for all reporting companies, of

(A) Report TI03, Lines TI03.46 (Messenger, Overnight and Delivery Service — Other), TI03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), TI03.53 (Equipment Rent), TI03.54 (Data Processing Services and Software), TI03.55 (Printing/Stationery/Supplies), TI03.56 (Telephone/Utilities), TI03.57 (Postage and Freight), TI03.58 (Accounting/Auditor Fees), TI03.59 (Director Fees), TI03.60 (Legal Fees), TI03.61 (Management Fees), TI03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), TI03.65 (Bad Debt Expense), TI03.66 (Insurance), TI03.69 (Trade Associations and Advisory Organizations), TI03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations) and TI03.72 (Aggregate Write–Ins for Other Expenses), Column TI03.D (California Current Year);

(B) Report TI04, Lines TI04.06 (General Management) and TI04.15 (Courier and Delivery — Other), Column TI04.M (Total Personnel Costs);

(C) Report UTC03, Lines UTC03.46 (Messenger, Overnight and Delivery Service — Other), UTC03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), UTC03.53 (Equipment Rent), UTC03.54 (Data Processing Services and Software), UTC03.55 (Printing/Stationery/Supplies), UTC03.56 (Telephone/Utilities), UTC03.57 (Postage and Freight), UTC03.58 (Accounting/Auditor Fees), UTC03.59 (Director Fees), UTC03.60 (Legal Fees), UTC03.61 (Management Fees), UTC03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), UTC03.65 (Bad Debt Expense), UTC03.66 (Insurance), UTC03.69 (Trade Associations and Advisory Organizations), UTC03.70 (Dues/Subscriptions Other than Trade and Advisory Orga-

nizations) andUTC03.72 (Aggregate Write-Ins for Other Expenses), Column UTC03.D (California Current Year)

(D) Report TI04, Lines TI04.06 (General Management) and TI04.15 (Courier and Delivery — Other), Column TI04.M (Total Personnel Costs);

(2) less the sum, for all reporting companies, of

(A) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non-Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.46 (Messenger, Overnight and Delivery Service — Other), TI03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), TI03.53 (Equipment Rent), TI03.54 (Data Processing Services and Software), TI03.55 (Printing/Stationery/Supplies), TI03.56 (Telephone/Utilities), TI03.57 (Postage and Freight), TI03.58 (Accounting/Auditor Fees), TI03.59 (Director Fees), TI03.60 (Legal Fees), TI03.61 (Management Fees), TI03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), TI03.65 (Bad Debt Expense), TI03.66 (Insurance), TI03.69 (Trade Associations and Advisory Organizations), TI03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations), TI03.72 (Aggregate Write-Ins for Other Expenses) TI04.06 (General Management) or TI04.15 (Courier and Delivery — Other);

(B) Report UTC07, Column UTC07.H for all lines in which the entry in Column TIUTC07.D is 1 (Affiliated Licensee) or 3 (Non-Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.46 (Messenger, Overnight and Delivery Service — Other), UTC03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), UTC03.53 (Equipment Rent), UTC03.54 (Data Processing Services and Software), UTC03.55 (Printing/Stationery/ Supplies), UTC03.56 (Telephone/Utilities), UTC03.57 (Postage and Freight), UTC03.58 (Accounting/Auditor Fees), UTC03.59 (Director Fees), UTC03.60 (Legal Fees), UTC03.61 (Management Fees), UTC03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), UTC03.65 (Bad Debt Expense), UTC03.66 (Insurance), UTC03.69 (Trade Associations and Advisory Organizations), UTC03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations), UTC03.72 (Aggregate Write-Ins for Other Expenses) UTC04.06 (General Management) or UTC04.15 (Courier and Delivery — Other).

(ab) Federal income tax rate, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, row TI12.14 (Federal Income Tax), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) Report UTC12, row UTC12.14 (Federal Income Tax), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) Report TI12, row TI12.12 (Net Income Before Taxes), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) Report UTC12, row UTC12.12 (Net Income Before Taxes), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ac) State income tax rate, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) the sum of Report TI12, row TI12.13 (State Income Tax), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) the sum of Report UTC12, row UTC12.13 (State Income Tax), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) the sum of Report TI12, row TI12.12 (Net Income Before Taxes), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) the sum of Report UTC12, row UTC12.12 (Net Income Before Taxes), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ad) Investment income yield, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, row TI12.09 (Net Investment Income), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California) and

(B) Report UTC12, row UTC12.09 (Net Investment Income), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California)

(2) to the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.B (Current Year — California) and TI12.E (Third Prior Year — California);

(B) Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California);

(C) one-half of Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.B (Current Year — California) and UTC12.E (Third Prior Year — California);

(D) Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California).

(ae) Capital gain yield, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, lines TI12.10 (Realized Capital Gains) and TI12.11 (Unrealized Capital Gains), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(B) Report UTC12, row UTC12.10 (Realized Capital Gains) and UTC12.11 (Unrealized Capital Gains), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.B (Current Year — California) and TI12.G (Fifth Prior Year — California);

(B) Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(C) one-half of Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.B (Current Year — California) and UTC12.G (Fifth Prior Year — California); and

(D) Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(af) Reserves to revenue ratio, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.22 (Total Reserves), columns TI12.B (Current Year — California) and TI12.G (Fifth Prior Year — California);

(B) Report TI12, row TI12.22 (Total Reserves), columns TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(C) one-half of Report UTC12, row UTC12.22 (Total Reserves), columns UTC12.B (Current Year — California) and UTC12.G (Fifth Prior Year — California); and

(D) Report UTC12, row UTC12.22 (Total Reserves), columns UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) Report TI12, row TI12.06 (Total Operating Revenue), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(B) Report UTC12, row UTC12.06 (Total Operating Revenue), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ag) Net worth to revenue ratio, computed as is the average of

(1) the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.26 (Total Equity), columns TI12.B (Current Year — California) and TI12.G (Fifth Prior Year — California);

(B) Report TI12, row TI12.26 (Total Equity), columns TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(C) one-half of Report UTC12, row UTC12.26 (Total Equity), columns UTC12.B (Current Year — California) and UTC12.G (Fifth Prior Year — California); and

(D) Report UTC12, row UTC12.26 (Total Equity), columns UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) Report TI12, row TI12.06 (Total Operating Revenue), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California); and

(B) Report UTC12, row UTC12.06 (Total Operating Revenue), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ah) Total policy issuance and maintenance costs, computed as

(1) the quantity,

(A) the sum, for all reporting companies, of

(i) Report TI03, line TI03.36 (Title Policy Issuance and Maintenance), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.04 (Title Policy Issuance and Maintenance), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, line UTC03.36 (Title Policy Issuance and Maintenance), Column UTC03.D (California Current Year); and

(iv) Report UTC04, Line UTC04.04 (Title Policy Issuance and Maintenance), Column UTC04.M (Total Personnel Costs);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non-Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.36 (Title Policy Issuance and Maintenance) or TI04.04 (Title Policy Issuance and Maintenance); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTC07.D is 1 (Affiliated Licensee) or 3 (Non-Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.36 (Title Policy Issuance and Maintenance) or UTC04.04 (Title Policy Issuance and Maintenance);

(2) multiplied by the ratio of

(A) total title insurance company retained title insurance premium

(B) to the sum, for all reporting companies, of

(i) total title insurance company retained title insurance premium; and

(ii) total title policy issuance related other service revenue.

(ai) Total title loss and loss adjustment factor, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, Line TI12.07 (Total Title Loss and Loss Settlement Expense), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(B) Report UTC12, row UTC12.07 (Total Title Loss and Loss Settlement Expense), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of Report TI16, Row TI16.003 (Amount of Insurance), columns TI16.S (Fourth Prior Year), TI16.T (Third Prior Year), TI16.U (Second Prior Year), TI16.V (First Prior Year) and TI16.W (Current Year).

(aj) average title policy class relativity ($ClassRel_{avg}$), computed as

(1) the sum of the following amounts calculated individually for each title insurance company:

(A) Report TI14, Column TI14.N (Owner's Policy Basic Premium), TI14.Q (Lender's 1 Policy Basic Premium), and TI14.T (Lender's Policy 2 Basic Premium); divided by

(B) Report TI14, Column TI14.AD (Total Premium for Title Insurance Policies), multiplied by

(C) the relativity in section 2357.17 for the company's base policy; multiplied by

(D) Report TI14, Column TI14.N (Owner's Policy Basic Premium), TI14.Q (Lender's Policy 1 Basic Premium), and TI14.T (Lender's Policy 2 Basic Premium);

(2) divided by the sum for all reporting companies of

(A) Report TI14, Column TI14.N (Owner's Policy Basic Premium), TI14.Q (Lender's Policy 1 Basic Premium), and TI14.T (Lender's Policy 2 Basic Premium).

(ak) Individual title insurance company gross premium, computed as Report TI03, row TI03.01 (Gross Written Title Premium), column TI03.D (California Current Year Total) for the title insurance company issuing the title insurance policy.

(al) Individual title insurance company retained premium, computed as Report TI03, row TI03.01 (Gross Written Title Premium), column TI03.D (California Current Year Total) less Report TI03, row TI03.012 (Title Premium Retained by or Remitted to Underwritten Title Companies), column TI03.D (California Current Year Total) for the title insurance company issuing the title insurance policy.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.4. Determination of Projected Values for Title Insurance.

The Commissioner, in consultation with the advisory organizations, shall, no less frequently than annually, determine and publish the following factors:

(a) the projected number of preliminary report transactions, consisting of the total preliminary report transactions multiplied by the transactions growth factor raised to the quantity the number of months between the midpoint of the historical period and the midpoint of the effective period divided by 12;

(b) the projected number of title insurance transactions, consisting of the total title insurance transactions multiplied by the transactions growth factor raised to the quantity the number of months between the midpoint of the historical period and the midpoint of the effective period divided by 12;

(c) the projected title plant maintenance component (TitlePlantMaint), consisting of

(1) the corrected total title plant maintenance cost

(2) divided by the projected number of preliminary report transactions;

(d) the projected preliminary report taxes, licenses, and fees component (PRTLF), consisting of

(1) the adjusted total taxes, licenses, and fees; multiplied by the ratio of

(2) total underwritten title company retained title insurance premium to total revenue;

(3) divided by the projected number of preliminary report transactions;

(dd) the projected preliminary report facility rent (PRRent), calculated as

(1) the adjusted total facility rent;, multiplied by the ratio of

(2) total preliminary report related full-time equivalent workers, as specified in Section 2357.3(c); to total full-time equivalent workers; divided by.

(3) the projected number of preliminary report transactions.

(e) the projected search, examination, and underwriting component (SrchExamUw), consisting of

(1) the adjusted total search, examination, and underwriting costs

(2) divided by the total amount of insurance multiplied by the quantity the market value growth factor raised to the number of months from the midpoint of the historical period to the midpoint of the effective period divided by 12;

(f) the projected preliminary report production and delivery component (PrelimRptProdDeliv), consisting of

(1) the adjusted total preliminary report production and delivery cost

(2) divided by the total amount of insurance multiplied by the market value growth factor raised to the quantity the number of months from the midpoint of the historical period to the midpoint of the effective period divided by 12;

(g) the projected preliminary report overhead component (PrelimRptOH), consisting of

(1) the adjusted total overhead

(2) multiplied by the ratio of the total undewritten title company retained title insurance premium to total revenue;

(3) divided by the total amount of insurance multiplied by the market value growth factor raised to the quantity the number of months from the midpoint of the historical period to the midpoint of the effective period divided by 12;

(h) the projected policy issuance and maintenance component (PolIssMaint), consisting of

(1) the adjusted total policy issuance and maintenance cost

(2) divided by the total amount of insurance multiplied by the market value growth factor raised to the quantity the number of months from the midpoint of the historical period to the midpoint of the effective period divided by 12;

(i) the projected loss component (Loss), equal to the total title loss and loss adjustment factor in section 2357.3(ai).

(j) the projected policy taxes, licenses, and fees component (PolTLF), consisting of

(1) the adjusted total taxes, licenses, and fees, multiplied by the ratio

(2) total title insurance company retained title insurance premium to total revenue;

(3) divided by the projected total number of title insurance transactions;

(k) the projected title policy facility rent (PolRent) consisting of

(1) the projected total facility rent; multiplied by the ratio of

(2) total title insurance policy related full-time equivalent workers to total full-time equivalent workers; divided by

(3) divided by the projected total number of title insurance transactions;

(*l*) the projected policy overhead component (PolOH), consisting of

(1) the projected totaloverhead, multiplied by the ratio of

(2) total title insurance company retained title insurance premium retained to total revenue;

(3) divided by the total amount of insurance multiplied by the market value growth factor raised to the quantity the number of months from the midpoint of the historical period to the midpoint of the effective period divided by 12.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.5. Maximum Title Insurance Charge for a Policy.

(a) The maximum title insurance charge for a given policy ($MaxTIC_{policy}$) means

(1) the maximum average title insurance charge for the amount of insurance ($MaxTIC_{amt}$), as specified in section 2357.6, divided by

(2) the average title policy class relativity ($ClassRel_{avg}$), as specified in section 2357.3, multiplied by

(3) the class relativity for the policy ($ClassRel_{policy}$), as specified in section 2357.17.

Stated as an equation,

$$MaxTIC_{policy} = \frac{MaxTIC_{amt}}{ClassRel_{avg}} * ClassRel_{policy}$$

(b) Notwithstanding the foregoing, the charge for a concurrent policy shall not exceed $25 plus $0.10 per page, exclusive of reasonable charges for any inspection required in the ordinary course of business solely for the concurrent policy. For purposes of this section, the concurrent policy or policies shall be any policy for which the maximum title insurance charge pursuant to this section is less than another policy issued at the same time, disregarding the concurrency.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7-26-2007; operative 11-23-2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.6. Maximum Average Title Insurance Charge.

(a) "Maximum average title insurance charge" for a given amount of insurance means

(1) the sum of

(A) the preliminary report charge (PrelimRprtChg), as specified in section 2357.7,

(B) plus the policy charge (PolicyChg), as specified in section 2357.13,

(2) divided by

(A) 1 minus

(B) the product of

(i) the premium tax rate (PremTaxR), as specified in section 2357.15, multiplied by

(ii) the title insurer retention rate (RetnR), as specified in section 2357.16.

Stated as an equation,

$$MaxTIC_{amt} = \frac{PrelimRprtChg + PolicyChg}{1 - (PremTaxR * RetnR)}$$

(b) Where the transaction results in issuance of a policy, the charge shall include the preliminary report charge and the policy charge, and no additional charge for the preliminary report may be made.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.7. Preliminary Report Charge.

"Preliminary report charge" for a given amount of insurance ($PrelimRptChg_{amt}$) means

(a) the sum of

(1) the title plant maintenance component (TitlePlantMaint);

(2) the preliminary report taxes, licenses, and fees component (PRTLF);

(3) the preliminary report facility rent component (PRRent); plus

(4) the amount of insurance (Amt) multiplied by the sum of

(A) the search, examination, and underwriting component (SrchExam Uw),

(B) the preliminary report production and delivery component (PRProdDeliv), and

(C) the preliminary report overhead component (PROH),

(b) divided by the quantity

(1) 1; less

(2) the profit factor (Profit), as specified in section 2357.8, divided by the state and federal income tax factor (SFIT), as specified in section 2357.10, plus

(3) the investment income factor (InvInc), as specified in section 2357.11, less

(4) the sales cost factor (Sls), as specified in section 2357.12.

Stated as an equation,

$$PrelimRptChg_{amt} = \frac{Title\ Plant + PRTLF + PRRent + Amt * (SrchExamUw + PRProdDeliv + PROH)}{1 - \frac{Profit}{SFIT} + InvInc - Sls}$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.8. Profit Factor.

"Profit factor" means

(a) the maximum rate of return (ROR), as specified in section 2357.9,

(b) multiplied by the net worth to revenue ratio (Capital), as specified in section 2357.3.

Stated as an equation

$$Profit = ROR * Capital$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.9. Maximum Rate of Return.

"Maximum rate of return" (ROR) means

(a) the average return on short, medium and long–term U.S. Treasury bonds for the most recent three months

(b) plus 6 percent, which the Commissioner finds represents the long–term risk–premium for investments presenting risks to investors comparable to the risks in investing in the title–insurance business.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.10. State and Federal Income Tax Factor.

"State and federal income tax factor" means 1 minus the sum of the federal income tax rate and the state income tax rate.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.11. Investment Income Factor.

"Investment income factor" (InvInc) means the product of

(1) the sum of

(A) the investment income yield, and

(B) the capital gains yield, times

(2) the sum of

(A) the reserves to revenue ratio, and

(B) the net worth to revenue ratio as those quantities are calculated from the most recent results reported for the statistical plan.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.12. Sales Cost Factor.

"Sales cost factor" means 15 percent, which the Commissioner finds to be a reasonable cost for salaries and commissions for sales, other acquisition expenses, and customer service expenses.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.13. Policy Charge.

"Policy charge" for a given amount of insurance ($PolicyChg_{amt}$) means

(a) the sum of

(1) the policy taxes, licenses, and fees component (PolTLF);

(2) the title policy facility rent component (PolRent); and

(3) the amount of insurance multiplied by the sum of

(A) the policy issuance and maintenance component (PolIssMaint);

(B) the loss and loss adjustment component (Loss); and

(C) the policy overhead component (PolOH)

(b) divided by the sum of

(1) 1 less

(2) the profit factor (Profit), as specified in section 2357.8, divided by the federal income tax factor (FIT), as specified in section 2357.14, plus

(3) the investment income factor (InvInc), as specified in section 2357.11; less

(4) the sales charge factor, as specified in section 2357.12.

Stated as an equation,

$$PolicyChg_{amt} = \frac{PolTLF + PolRent + Amt * (PolIssMaint + Loss + PolOH)}{1 - \frac{Profit}{FIT} + InvInc - Sls}$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.14. Federal Income Tax Factor.

"Federal income tax factor" means 1 minus the federal income tax rate, as specified in section 2357.3.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.15. Premium Tax Rate.

"Premium tax rate" means the state premium tax rate pursuant to Revenue and Tax Section 12202.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.2, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code; and Section 12202, Revenue and Taxation Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.16. Retention Rate.

"Retention rate" (RR) means

(a) individual title insurance company retained premium, as specified in section 2357.3, divided by

(b) individual title insurance company gross premium as specified in section 2357.3.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.17. Relativities.

"Class relativity for a policy" means the product of all the relativities listed in the following table that are applicable to the policy.

	Relativity for	*Relativity*
Policy form	CLTA Standard Coverage Policy — Owner	1.00
	CLTA Standard Coverage Policy — Lender	0.80
	CLTA Expanded Coverage Residential Loan Policy	1.15
	CLTA Homeowners Policy	1.10
	ALTA Owners (Full Extended Coverage) Policy — Buyer	1.20
	ALTA Owners (Full Extended Coverage) Policy — Lender	1.00
	ALTA Expanded Coverage Residential Loan Policy	1.15
	ALTA Short Form Expanded Coverage Residential Loan Policy	1.10
	CLTA and ALTA Homeowners Policy	1.10
	CLTA Form 119.5 — Leasehold–Owners	1.00
	CLTA Form 119.6 — Leasehold–Loan	1.00
	CLTA Form 101 Mechanics Lien Priority Insurance Coverage	1.10
Recency	Ordered >60 months from last previous policy issued by any title insurer	1.00
	Ordered within 60 months of last pervious policy issued by any title insurer — Owner	0.80
	Ordered within 60 months of last previous policy issued by any title insurer — Lender	0.64
Sale/Refinance	Sale of new or existing home	1.00
	Refinancing of home — CLTA Policy	0.55
	Refinancing of home — ALTA Policy	0.65
Subdivision	Not first sale of parcel after land subdivided	1.00
	First sale of parcel after land subdivided — 2 to 20 units	0.70
	First sale of parcel after land subdivided — >20 units	0.55

(b) A title insurer may employ any relativity it chooses so long as the resulting charge for a policy does not exceed the maximum title insurance charge for that policy pursuant to section 2357.6 and does not exceed any applicable interim maximum rate pursuant to section 2357.19.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.18. Endorsements.

(a) "Endorsement factor for a policy" means 1 multiplied by the product of each of the factors listed in the following table that are applicable to the policy.

Endt #	*Description*	*Policy Form*	*Relativity*
100	Restrictions, Easements, Minerals	Lender ALTA	1.00
100.1	Restrictions, Easements, Minerals	Lender CLTA	1.20
100.2	Restrictions, Easements, Minerals	Lender ALTA	1.00
ALTA 9	Restrictions, Easements, Minerals	Lender ALTA	1.00
100.4	Present Violation of Particular CC&R's	Lender ALTA	1.05
100.4	Present Violation of Particular CC&R's	Lender CLTA	1.10
100.5	Present Violation of Particular CC&R's	Owner ALTA	1.05
100.5	Present Violation of Particular CC&R's	Owner CLTA	1.20
100.6	Present or Future Violation of CC&R's	Owner ALTA	1.05
100.6	Present or Future Violation of CC&R's	Owner CLTA	1.20
100.7	Present Violation of Particular CC&R's	Owner ALTA	1.05
100.7	Present Violation of Particular CC&R's	Owner CLTA	1.20
100.8	Present or Future Violation of CC&R's	Owner ALTA	1.05
101.8	Present or Future Violation of CC&R's	Owner CLTA	1.20
102.8	Present or Future Violation of CC&R's	Lender ALTA	1.10
100.9	Restrictions, Encroachments, Minerals — Unimproved land	Owner ALTA	1.10
ALTA 9.1	Restrictions, Encroachments, Minerals — Unimproved land	Owner CLTA	1.10
100.10	Restrictions, Encroachments, Minerals — Improved land	Owner ALTA	1.15
ALTA 9.2	Restrictions, Encroachments, Minerals — Improved land	Owner CLTA	1.15
100.12	Reverter, Right of Re–entry of Power of Termination in CC&R's Not Enforceable	Lender ALTA	1.015
100.13	Lien of Assessment in CC&R's Subordinate to Insured Mortgage	Lender ALTA	1.015
100.17	Modification of Restrictions is Proper	Owner ALTA	1.20
101.17	Modification of Restrictions is Proper	Owner CLTA	1.20
102.17	Modification of Restrictions is Proper	Lender ALTA	1.10
103.17	Modification of Restrictions is Proper	Lender CLTA	1.10
100.18	Exercise of Reverter, Right of Re–entry of Power of Termination in CC&R's & Unmarketability	Lender ALTA	1.015
101.18	Exercise of Reverter, Right of Re–entry of Power of Termination in CC&R's & Unmarketability	Lender CLTA	1.015
100.19	No Present Violations of CC&R's	Owner ALTA	1.025
101.19	No Present Violations of CC&R's	Owner CLTA	1.20
102.19	No Present Violations of CC&R's	Lender ALTA	1.025
103.19	No Present Violations of CC&R's	Lender CLTA	1.10
100.20	Enforcement of CC&R's based on Present Value	Owner ALTA	1.025
101.20	Enforcement of CC&R's based on Present Value	Owner CLTA	1.20
102.20	Enforcement of CC&R's based on Present Value	Lender ALTA	1.025
103.20	Enforcement of CC&R's based on Present Value	Lender CLTA	1.10
100.21	Approval of Plans & Specifications Required by CC&R's	Owner ALTA	1.20
101.21	Approval of Plans & Specifications Required by CC&R's	Owner CLTA	1.20
102.21	Approval of Plans & Specifications Required by CC&R's	Lender ALTA	1.025
103.21	Approval of Plans & Specifications Required by CC&R's	Lender CLTA	1.10
100.23	Right of Surface Entry Under Oil Lease	Lender ALTA	1.025
101.23	Right of Surface Entry Under Oil Lease	Lender CLTA	1.025
100.24	Lessee Does Not Have Right to Use the Surface	Owner ALTA	1.10
101.24	Lessee Does Not Have Right to Use the Surface	Owner CLTA	1.10
102.24	Lessee Does Not Have Right to Use the Surface	Lender ALTA	1.10
103.24	Lessee Does Not Have Right to Use the Surface	Lender CLTA	1.10
100.25	Subsurface Oil Drilling Does Not Violate CC&R's	Lessee: S	1.20
101.25	Subsurface Oil Drilling Does Not Violate CC&R's	CLTA	1.20
102.25	Subsurface Oil Drilling Does Not Violate CC&R's	Lender ALTA	1.20
100.26	Damage to Improvements Resulting From Right to Use Surface (FHA)	Owner ALTA	1.10
101.26	Damage to Improvements Resulting From Right to Use Surface (FHA)	Owner CLTA	1.20
102.26	Damage to Improvements Resulting From Right to Use Surface (FHA)	Lender ALTA	1.10
103.26	Damage to Improvements Resulting From Right to Use Surface (FHA)	Lender CLTA	1.10
100.27	Present Violation of CC&R's	Lender ALTA	1.05
100.28	Violation of Particular Provisions of CC& R's by Future Construction	Owner ALTA	1.20
101.28	Violation of Particular Provisions of CC& R's by Future Construction	Owner CLTA	1.20
102.28	Violation of Particular Provisions of CC& R's by Future Construction	Lender ALTA	1.10
103.28	Violation of Particular Provisions of CC& R's by Future Construction	Lender CLTA	1.10
100.29	Mineral Rights — Damage to Improvements	Owner ALTA	1.10
101.29	Mineral Rights — Damage to Improvements	Owner CLTA	1.20
102.29	Mineral Rights — Damage to Improvements	Lender ALTA	1.10
103.29	Mineral Rights — Damage to Improvements	Lender CLTA	1.10
101	M/L Priority Insurance	Lender CLTA	1.10
101.1	M/L Insurance After Notice of Completion	Owner ALTA	1.20
102.1	M/L Insurance After Notice of Completion	Owner CLTA	1.20
103.1	M/L Insurance After Notice of Completion	Lender ALTA	1.20
104.1	M/L Insurance After Notice of Completion	Lender CLTA	1.20
101.1–A	M/L Insurance After Notice of Completion DVA	Owner ALTA	1.10
101.1–A	M/L Insurance After Notice of Completion DVA	Owner CLTA	1.10
101.2	M/L Insurance After Notice of Completion	Lender ALTA	1.10
102.2	M/L Insurance After Notice of Completion	Lender CLTA	1.10
101.3	M/L Insurance After Notice of Completion	Lender ALTA	1.10

Endt #	*Description*	*Policy Form*	*Relativity*
102.3	M/L Insurance After Notice of Completion	Lender CLTA	1.10
101.4	M/L Insurance After Notice of Completion	Owner ALTA	1.10
102.4	M/L Insurance After Notice of Completion	Owner CLTA	1.20
103.4	M/L Insurance After Notice of Completion	Lender ALTA	1.10
104.4	M/L Insurance After Notice of Completion	Lender CLTA	1.10
101.5	M/L Insurance — Notice of Completion regular & Liens Listed; Liability Limited to Specific Amount	Lender All Policies where End. 101 is not used	1.025
101.6	M/L Insurance — Notice of Completion regular & Liens Listed; Liability Limited to Specific Amount	Lender All Policies where End. 101 is used	1.025
101.8	Work of Improvement Financed by Insured Mortgage	Lender ALTA	1.10
102.8	Work of Improvement Financed by Insured Mortgage	Lender CLTA	1.10
101.9	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Owner ALTA	1.20
102.9	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Owner CLTA	1.20
103.9	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Lender ALTA	1.10
104.9	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Lender CLTA	1.10
101.10	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Owner ALTA	1.20
102.10	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Owner CLTA	1.10
103.10	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Lender ALTA	1.10
104.10	M/L Insurance — Notice of Completion describes Specific Work of Improvement on Only a Portion of Land Covered by Policy	Lender CLTA	1.10
101.11	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Owner ALTA	1.20
102.11	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Owner CLTA	1.10
103.11	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Lender ALTA	1.10
104.11	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Lender CLTA	1.10
101.12	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Owner ALTA	1.20
102.12	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Owner CLTA	1.20
103.12	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Lender ALTA	1.10
104.12	M/L Insurance — As to Only a Portion of Land Covered by Policy — No Notice of Completion	Lender CLTA	1.10
101.13	M/L Insurance After Notice of Completion	Owner ALTA	1.20
102.13	M/L Insurance After Notice of Completion	Owner CLTA	1.10
103.13	M/L Insurance After Notice of Completion	Lender ALTA	1.10
104.13	M/L Insurance After Notice of Completion	Lender CLTA	1.10
101.14	Construction	Lender ALTA	1.10
101.15	Mechanics Lien, Completed Work of Improvement	Lender ALTA	1.10
101.16	Mechanics Lien, Notice of Completion	Lender ALTA	1.10
101.17	Mechanics Lien, Completed Work of Improvement	Lender ALTA	1.10
101.18	Mechanics Lien, Notice of Completion	Lender ALTA	1.10
102.4	Foundations Are Within Boundary Lines, Do Not Violate CC&R's	Lender ALTA	1.10
103.4	Foundations Are Within Boundary Lines, Do Not Violate CC&R's	Lender CLTA	1.10
102.5	Foundations Are Within Boundary Lines, Do Not Violate CC&R's, No Encroachment Onto Easements	Lender ALTA	1.15
103.5	Foundations Are Within Boundary Lines, Do Not Violate CC&R's, No Encroachment Onto Easements	Lender CLTA	1.15
102.6	Foundations Are Within Boundary Lines, Do Not Violate CC&R's	Lender ALTA	1.10
103.6	Foundations Are Within Boundary Lines, Do Not Violate CC&R's	Lender CLTA	1.10
102.7	Foundations Are Within Boundary Lines, Do Not Violate CC&R's, No Encroachment Onto Easements	Lender ALTA	1.15
103.7	Foundations Are Within Boundary Lines, Do Not Violate CC&R's, No Encroachment Onto Easements	Lender CLTA	1.15
103.1	Exercise of Right of Use or Maintenance of Easement	Owner ALTA	1.20
104.1	Exercise of Right of Use or Maintenance of Easement	Owner CLTA	1.20
105.1	Exercise of Right of Use or Maintenance of Easement	Lender ALTA	1.025
106.1	Exercise of Right of Use or Maintenance of Easement	Lender CLTA	1.10
103.3	Forced Removal of Improvements Which Encroach into Easements	Owner ALTA	1.20
104.3	Forced Removal of Improvements Which Encroach into Easements	Owner CLTA	1.20
105.3	Forced Removal of Improvements Which Encroach into Easements	Lender ALTA	1.025
106.3	Forced Removal of Improvements Which Encroach into Easements	Lender CLTA	1.10
103.4	Insured Easement provides ingress & egress	Owner ALTA	1.20
104.4	Insured Easement provides ingress & egress	Owner CLTA	1.20
105.4	Insured Easement provides ingress & egress	Lender ALTA	1.10
106.4	Insured Easement provides ingress & egress	Lender CLTA	1.10
103.5	Water Rights — Damage to Improvements	Owner ALTA	1.20
104.5	Water Rights — Damage to Improvements	Owner CLTA	1.20
105.5	Water Rights — Damage to Improvements	Lender ALTA	1.10
106.5	Water Rights — Damage to Improvements	Lender CLTA	1.10
103.6	No Encroachment onto Specific Easement	Owner ALTA	1.10
104.6	No Encroachment onto Specific Easement	Owner CLTA	1.10
105.6	No Encroachment onto Specific Easement	Lender ALTA	1.10
106.6	No Encroachment onto Specific Easement	Lender CLTA	1.10
103.7	Land Abuts Existing Street	Owner ALTA	1.10

Endt #	*Description*	*Policy Form*	*Relativity*
104.7	Land Abuts Existing Street	Owner CLTA	1.20
105.7	Land Abuts Existing Street	Lender ALTA	1.10
106.7	Land Abuts Existing Street	Lender CLTA	1.10
103.8	Water Rights — Damage to Existing or Future Improvements (FHA)	Owner ALTA	1.10
104.8	Water Rights — Damage to Existing or Future Improvements (FHA)	Owner CLTA	1.10
105.8	Water Rights — Damage to Existing or Future Improvements (FHA)	Lender ALTA	1.10
106.8	Water Rights — Damage to Existing or Future Improvements (FHA)	Lender CLTA	1.10
103.9	Forced Removal of Encroachments onto Public Street	Owner ALTA	1.10
104.9	Forced Removal of Encroachments onto Public Street	Owner CLTA	1.10
105.9	Forced Removal of Encroachments onto Public Street	Lender ALTA	1.10
106.9	Forced Removal of Encroachments onto Public Street	Lender CLTA	1.10
103.10	Surface Owner Insurer Against Use of Surface by Owner of Land Below the Horizontal Division of Land	Owner ALTA	1.20
104.10	Surface Owner Insurer Against Use of Surface by Owner of Land Below the Horizontal Division of Land	Owner CLTA	1.20
105.10	Surface Owner Insurer Against Use of Surface by Owner of Land Below the Horizontal Division of Land	Lender ALTA	1.20
106.10	Surface Owner Insurer Against Use of Surface by Owner of Land Below the Horizontal Division of Land	Lender CLTA	1.20
103.11	Access & Entry	Owner ALTA	
104.11	Access & Entry	Owner CLTA	1.25
105.11	Access & Entry	Lender ALTA	1.15
106.11	Access & Entry	Lender CLTA	1.15
103.12	Indirect Access & Entry	Owner ALTA	1.25
104.12	Indirect Access & Entry	Owner CLTA	1.25
105.12	Indirect Access & Entry	Lender ALTA	1.25
106.12	Indirect Access & Entry	Lender CLTA	1.15
104	Assignment of Beneficial Interest	Lender ALTA	1.30
104A	Assignment of Beneficial Interest	Lender CLTA	1.25
104.1	Assignment of Beneficial Interest	Lender ALTA	1.25
105.1	Assignment of Beneficial Interest	Lender CLTA	1.15
104.4	Collateral Assignment of Beneficial Interest	Lender ALTA	1.15
105.4	Collateral Assignment of Beneficial Interest	Lender CLTA	1.15
104.6	Assignment of Lessor's Interest in Lease — No Defect in Execution, No Prior Assignment	Lender ALTA	1.05
104.7	No Prior Assignment of Rents	Lender ALTA	1.05
105.7	No Prior Assignment of Rents	Lender CLTA	1.05
104.8	Assignment of Beneficial Interest	Lender ALTA	1.30
104.9	Assignment of Beneficial Interest	Lender CLTA	1.25
104.10	Assignment of Beneficial Interest	Lender ALTA	1.25
105.10	Assignment of Beneficial Interest	Lender CLTA	1.25
104.11	Collateral Assignment of Beneficial Interest	Lender ALTA	1.25
105.11	Collateral Assignment of Beneficial Interest	Lender CLTA	1.25
104.12	Assignment of Beneficial Interest	Lender ALTA	1.25
104.13	Assignment of Beneficial Interest	Lender ALTA	1.30
105	Insuring Two of More Deeds of Trust	Lender ALTA	1.10
105.1	Insuring Two of More Deeds of Trust	Lender CLTA	1.10
106	State of California — Abutters Rights	Owner CLTA	1.045
106C	State of California — Abutters Rights	Owner CLTA	1.045
106C	State of California — Abutters Rights	Owner ALTA	1.015
106.1	State of California — Abutters Rights	Owner CLTA	1.05
107.1	State of California — Abutters Rights	Owner ALTA	1.00
106.1C	State of California — Abutters Rights	Owner CLTA	1.05
106.1C	State of California — Abutters Rights	Owner ALTA	1.00
106.2	State of California — Abutters Rights	Owner CLTA	1.06
106.2C	State of California — Abutters Rights	Owner CLTA	1.04
106.2C	State of California — Abutters Rights	Owner ALTA	1.01
107.1	Allocation of Liability	All Policies	1.02
107.2	Increased Liability	All Policies	1.00
107.4	To whom and in what priority loss is payable	All Policies	1.025
107.5	Improvements Included in Policy Coverage for Purposes of Establishing Damages	LenderLeasehold	1.025
107.9	Adding a Named Insured	All Policies	1.05
107.10	Adding a Named Insured	All Policies	1.05
107.11	When Mortgagee has also acquired a Fee Interest	Lender ALTA	1.10
108.7	Additional Advance	Owner ALTA	1.00
109.7	Additional Advance	Owner CLTA	1.00
110.7	Additional Advance	Lender ALTA	1.00
111.7	Additional Advance	Lender CLTA	1.65
108.8	Additional Advance	Owner ALTA	1.65
109.8	Additional Advance	Owner CLTA	1.65
110.8	Additional Advance	Lender ALTA	1.70
111.8	Additional Advance	Lender CLTA	1.00
108.9	Additional Advance — D.V.A	Owner ALTA	1.00
109.9	Additional Advance — D.V.A	Owner CLTA	1.80
110.9	Additional Advance — D.V.A	Lender ALTA	1.00
111.9	Additional Advance — D.V.A	Lender CLTA	1.00
108.10	Additional Advance — Revolving Credit	Lender CLTA	1.60
109.10	Additional Advance — Revolving Credit	Lender ALTA	1.70
109	No Transfer of Lessor's Benefits in Community Lease	Owner ALTA	1.10
110	No Transfer of Lessor's Benefits in Community Lease	Owner CLTA	1.20
111	No Transfer of Lessor's Benefits in Community Lease	Lender ALTA	1.10
112	No Transfer of Lessor's Benefits in Community Lease	Lender CLTA	1.20
110.1	Exception Deleted	Owner ALTA	1.20
111.1	Exception Deleted	Owner CLTA	1.20

Endt #	*Description*	*Policy Form*	*Relativity*
112.1	Exception Deleted	Lender ALTA	1.10
113.1	Exception Deleted	Lender CLTA	1.10
110.3	Mineral Interest owner's right of surface entry conveyed to owner of the surface	Owner ALTA	1.10
111.3	Mineral Interest owner's right of surface entry conveyed to owner of the surface	Owner CLTA	1.20
112.3	Mineral Interest owner's right of surface entry conveyed to owner of the surface	Lender ALTA	1.10
113.3	Mineral Interest owner's right of surface entry conveyed to owner of the surface	Lender CLTA	1.10
110.4	Modification of Deed of Trust — Specific Provision Quoted (no priority coverage)	Lender ALTA	1.15
110.5	Modification of Deed of Trust	Lender ALTA	1.35
110.6	Modification of Deed of Trust	Lender CLTA	1.25
110.7	Insurance against Enforcement of Lien of Encumbrance	Owner ALTA	1.10
111.7	Insurance against Enforcement of Lien of Encumbrance	Owner CLTA	1.10
112.7	Insurance against Enforcement of Lien of Encumbrance	Lender ALTA	1.10
113.7	Insurance against Enforcement of Lien of Encumbrance	Lender CLTA	1.10
110.9	Priority over Environmental Protection Lien	Owner ALTA	1.025
ALTA 8.1	Priority over Environmental Protection Lien	Owner CLTA	1.025
110.9	Priority over Environmental Protection Lien	Lender ALTA	1.025
ALTA 8.1	Priority over Environmental Protection Lien	Lender CLTA	1.025
110.10	Modification of Deed of Trust and Additional Advance	Lender ALTA	1.30
110.11 ALTA 11	Mortgage Modification		1.00
111	Partial Reconveyance, No Impairments	Lender ALTA	1.10
112	Partial Reconveyance, No Impairments	Lender CLTA	1.10
111.1	Partial Reconveyance, No Impairments — alternate form	Lender ALTA	1.10
112.1	Partial Reconveyance, No Impairments — alternate form	Lender CLTA	1.10
111.2	Mortgage Priority, Subordination	Owner ALTA	1.10
112.2	Mortgage Priority, Subordination	Owner CLTA	1.10
113.2	Mortgage Priority, Subordination	Lender ALTA	1.10
114.2	Mortgage Priority, Subordination	Lender CLTA	1.10
111.3	Mortgage Priority, Encroachment, Address	Lender ALTA	1.20
112.3	Mortgage Priority, Encroachment, Address	Lender CLTA	1.20
111.4	Housing & Urban Development End.	Lender ALTA	1.10
112.4	Housing & Urban Development End.	Lender CLTA	1.10
111.5	Variable Rate Mortgage	Lender ALTA	1.00
ALTA 6	Variable Rate Mortgage	Lender CLTA	1.00
111.6	Variable Rate Mortgage	Lender ALTA	1.00
ALTA 6.1	Variable Rate Mortgage	Lender CLTA	1.00
111.7	Variable rate mortgage	Lender ALTA	1.025
111.8	Variable rate mortgage	Lender ALTA	1.00
ALTA 6.2	Variable rate mortgage	Lender CLTA	1.00
111.9	FNMA Balloon Mortgage	Lender ALTA	1.025
112.9	FNMA Balloon Mortgage	Lender CLTA	1.00
111.10	Revolving Credit Loan	Lender ALTA	1.025
112.10	Revolving Credit Loan	Lender CLTA	1.025
111.11	Revolving Credit Loan	Lender ALTA	1.025
112.11	Revolving Credit Loan	Lender CLTA	1.025
111.14	Future Advance–Priority	Lender ALTA	1.05
112.14	Future Advance–Priority	Lender CLTA	1.00
112	Bondholders Policy	Lender CLTA	1.025
112.1	Bondholders Policy	Lender ALTA	1.025
113.1	Bondholders Policy	Lender CLTA	1.00
112.2	Bondholders Policy	Lender CLTA	1.025
113.2	Bondholders Policy	Lender ALTA	1.00
114	Co–insurance	Owner/Lender All Policies	1.00
114.1	Co–insurance — joint and several liability	Owner/Lender All Policies	1.00
114.2	Co–insurance — joint and several liability, proportioned loss	Owner/Lender All Policies	1.00
115	Condominium in fee	Owner All Policies	1.025
116	Condominium in fee	Lender All Policies	1.025
115.1	Condominium	Lender ALTA	1.00
ALTA 4	Condominium	Lender ALTA	1.00
115.2	Planned Unit Development	Lender ALTA	1.00
ALTA 5	Planned Unit Development	Lender ALTA	1.00
116	Designation of improvements, common address, location and dimensions	Lender ALTA	1.10
116.1	Land described in policy is same as shown on survey	Owner ALTA	1.10
117.1	Land described in policy is same as shown on survey	Owner CLTA	1.20
118.1	Land described in policy is same as shown on survey	Lender ALTA	1.025
119.1	Land described in policy is same as shown on survey	Lender CLTA	1.10
116.2	Designation of improvements, common address, project boundary dimensions (condominiums)	Owner ALTA	1.00
117.2	Designation of improvements, common address, project boundary dimensions (condominiums)	Owner CLTA	1.20
118.2	Designation of improvements, common address, project boundary dimensions (condominiums)	Lender ALTA	1.10
119.2	Designation of improvements, common address, project boundary dimensions (condominiums)	Lender CLTA	1.10
116.3	Description after map recorded	Owner ALTA	1.20
117.3	Description after map recorded	Owner CLTA	1.20
118.3	Description after map recorded	Lender ALTA	1.10
119.3	Description after map recorded	Lender CLTA	1.10
116.4	Contiguous parcels	Owner ALTA	1.20
117.4	Contiguous parcels	Owner CLTA	1.20
118.4	Contiguous parcels	Lender ALTA	1.10
119.4	Contiguous parcels	Lender CLTA	1.10
116.5	Manufactured Housing Unit	Owner ALTA	1.025
ALTA 7	Manufactured Housing Unit	Owner CLTA	1.025
117.5	Manufactured Housing Unit	Lender ALTA	1.025

Endt #	*Description*	*Policy Form*	*Relativity*
ALTA 8	Manufactured Housing Unit	Lender CLTA	1.025
116.6	Manufactured Housing Unit	Owner ALTA	1.025
117.6	Manufactured Housing Unit	Owner CLTA	1.025
118.6	Manufactured Housing Unit	Lender ALTA	1.025
119.6	Manufactured Housing Unit	Lender CLTA	1.025
116.7	Subdivision Map Act	Owner ALTA	1.10
117.7	Subdivision Map Act	Owner CLTA	1.10
118.7	Subdivision Map Act	Lender ALTA	1.10
119.7	Subdivision Map Act	Lender CLTA	1.10
117	Aggregation	Lender ALTA	1.10
119	Validity of lease	Owner ALTA	1.10
120	Validity of lease	Owner CLTA	1.10
121	Validity of lease	Lender ALTA	1.20
122	Validity of lease	Lender CLTA	1.20
119.1	Adds leasehold exceptions to Schedule B	Owner CLTA	1.025
120.1	Adds leasehold exceptions to Schedule B	Lender CLTA	1.025
121.1	Adds leasehold exceptions to Schedule B	Lender ALTA	1.00
119.2	Validity of lease	Owner ALTA	1.10
120.2	Validity of lease	Owner CLTA	1.10
121.2	Validity of lease	Lender ALTA	1.20
122.2	Validity of lease	Lender CLTA	1.10
119.3	Circuitry of lien makes priority doubtful	Owner ALTA	1.10
120.3	Circuitry of lien makes priority doubtful	Owner CLTA	1.10
121.3	Circuitry of lien makes priority doubtful	Lender ALTA	1.10
122.3	Circuitry of lien makes priority doubtful	Lender CLTA	1.10
119.4	Bondholders — valid sublease binding at commencement of term	Owner CLTA	1.025
120.4	Bondholders — valid sublease binding at commencement of term	Lender CLTA	1.025
120.2	Deed of trust subordinate to lease	Lessee Oil Leasehold	1.20
122	Priority of advance over intervening matters	Lender ALTA	1.10
123	Priority of advance over intervening matters	Lender CLTA	1.10
122.2	Priority of advance over intervening matters	Lender ALTA	1.10
122.2	Priority of advance over intervening matters	Lender CLTA	1.10
122.2	Priority of advance over intervening matters	Lender ALTA	1.10
122.4	Obligatory Advances	Lender ALTA	1.10
123.1 ALTA 3	Zoning — vacant land	Owner All Policies	1.10
123.1 ALTA 4	Zoning — vacant land	Lender All Policies	1.10
123.2 ALTA 3.1	Zoning — improved land	Owner All Policies	1.10
123.2 ALTA 3.1	Zoning — improved land	Lender All Policies	1.15
124.1	Affirmative and negative covenants in deeds or agreements except leases are binding	Owner ALTA	1.20
125.1	Affirmative and negative covenants in deeds or agreements except leases are binding	Owner CLTA	1.20
126.1	Affirmative and negative covenants in deeds or agreements except leases are binding	Lender ALTA	1.20
127.1	Affirmative and negative covenants in deeds or agreements except leases are binding	Lender CLTA	1.10
124.2	Lessor's affirmative covenants	Lessee All	1.20
125.2	Lessor's affirmative covenants	Lender All	1.10
124.3	Lessor's negative covenants	Lessee All	1.20
125.3	Lessor's negative covenants	Lender All	1.10
125	Truth in lending right of rescission	Lender ALTA	1.10
125.1	Truth in lending right of rescission	Lender CLTA	1.10
126	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner ALTA	1.00
127	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner CLTA	1.025
126.1	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner ALTA	1.00
127.1	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner CLTA	1.025
126.2	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner ALTA	1.00
127.2	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner CLTA	1.00
126.3	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner ALTA	1.025
127.3	Access, mechanic's liens, restrictions, easements, minerals, zoning	Owner CLTA	1.025

(b) A title insurer may employ any endorsement factor it chooses so long as the resulting charge for a policy does not exceed the maximum title insurance charge for that policy pursuant to section 2357.6 and does not exceed any applicable interim maximum title insurance rate pursuant to section 2357.19.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2357.19. Interim Maximum Title Insurance Rates.

(a)(1) Except as provided in subdivsion (e) of this section, commencing on October 1, 2010, no title insurance company may use any rate that produces premium charges for title–insurance policies, for endorsements, or for other charges that are computed on the basis of the amount of insurance or computed as a percentage of the basic premium, that exceeds the interim maximum title insurance rate (InterimMaxTitleRate), defined as the product of

(A) the premium that the title insurance company would have charged for the same policy, including endorsements and other charges, for the same transaction type, based on rates in effect for the title insurance company on December 31, 2000 ($2000TitleRate_{TransType}$), multiplied by

(B) 1 plus

(i) the title interim rate reduction for the transaction type ($TitleInterimReduction_{TransType}$,) specified in subdivision (a)(2) of this section, multiplied by

(ii) the sales price adjustment factor for the transaction type ($SPAF_{TransType}$) specified in subdivision (b) of this section.

Stated as a formula, the interim maximum title insurance rate effective October 1, 2010 is:

$$InterimMaxTitleRate = 2000TitleRate_{TransType} * (1 + TitleInterimReduction_{TransType} * SPAF_{TransType})$$

(2) The title interim rate reduction for the specified transaction type is defined as the value from the following table corresponding to the transaction type:

Transaction Type	*Title Interim Rate Reduction*
Title Purchase	-25.6%
Title Non-Purchase Refinance	-9.8%
Title Non-Purchase Other-Than-Refinance	-15.4%

(b)(1) The sales price adjustment factor is defined as follows, subject to the limitation that for a calculated amount less than or equal to 0 the value 0 shall be used and that for a calculated amount greater than 1 the value 1 shall be used:

(A) the quantity

(i) the sum of

(I) 0.93 75 multiplied by 2000–2010 inflation factor (InflationFactor), defined as the change in the consumer price index series SUUR0000SA0, not seasonally adjusted from June 2000 to May 2010 multiplied by the change in this consumer price index from June 2009 to May 2010, plus

(II) 0.0625 multiplied by 2000–2010 change in transaction size (ChangeTransSize), defined as the ratio of the most current California Association of Realtors forecast of median existing single-family home sales price for 2010 to $241,350,

(ii) divided by the sum of 1 plus the quantity

(I) the premium/transaction factor for the type of transaction ($PremTransFactor_{TransType}$), as specified, in subdivision (b)(2) of this section, multiplied by

(II) the 2000–2010 change in transaction size (ChangeTransSize) minus 1,

(iii) minus 1,

(B) multiplied by the quantity

(i) 1 divided by

(ii) the title interim rate reduction for the transaction type ($TitleInterimReduction_{TransType}$).

Stated as a formula:

$$SPAF_{TransType} = \left(\frac{.9375 * InflationFactor + .0625 * ChangeTransSize}{1 + (ChangeTransSize - 1) * PremTransFactor_{TransType}} - 1 \right) * \left(\frac{1}{TitleInterimReduction_{TransType}} \right)$$

(2) The premium/transaction factor for a specific transaction type means the value from the following table corresponding to the transaction type:

Transaction Type	*Premium/Transaction Factor*
Title Purchase	0.45854
Title Non-Purchase Refinance	0.24935
Title Non-Purchase Other-Than-Refinance	0.31655

(3) The Commissioner shall publish the values of the sales price adjustment factor for title insurance on or before July 30, 2010.

(c) Every title insurance company shall, no later than September 1, 2010, make a rate filing in conformance with this section covering the rates to be used on and after October 1, 2010.

(1) To the extent that a title insurance company intends to issue a policy or coverage or to provide a service for which it had no filed rate on December 31, 2000, it shall identify that policy, coverage, or service in its rate filing made pursuant to this section and shall demonstrate that the rate or charge is consistent with the rate-reduction mandated by this section.

(2) If a title insurance company has filed rate reductions effective on or after January 1, 2001, and the resulting rates are no greater than the maximum interim rates as specified in subdivisions (a) and (b) of this section, the title insurance company has satisfied the rate reduction requirements of subdivisions (a) and (b) with respect to those rates. If a title insurance company has filed rate reductions effective on or after January 1, 2001, and the resulting rates are greater than the maximum interim rates as specified in subdivisions (a) and (b), the title insurance company shall further reduce rates to satisfy the requirements of subdivisions (a) and (b) with respect to those rates. If a title insurance company has not changed rates or has increased rates effective on or after January 1, 2001, the title insurance company shall reduce its rates to satisfy the requirements of subdivisions (a) and (b) of this section.

(3) Nothing in this section shall preclude a title insurer or underwritten title company from filing a rate at any other time, provided that the rates comply with the applicable provisions of this section and with all other applicable provisions of law. Every policy that is subject to the provisions of subdivisions (a) or (b) of this section shall be reduced to a level no greater than that prescribed in those subdivisions. Failure to reduce an existing rate on any policy or service to the level prescribed by this section shall not be excused by a greater-than-specified reduction of other rates.

(d) The rate for each policy form and for each endorsement and other title service computed on the basis of the amount of insurance or computed as a percentage of the basic premium must satisfy the requirements of subdivisions (a), (b) and (c). Each title insurance company shall adjust its rates as necessary to ensure that the premium charge for a particular policy and transaction does not exceed the amount the title insurer would have charged for that policy and transaction based on rates in effect on December 31, 2000 less the relevant interim rate reduction percentage.

(e) The provisions of subdivisions (a) through (d) of this section shall not become operative if the Commissioner has, by July 30, 2010, published all of the projection factors specified in section 2357.4 and all of the totals specified in section 2357.3. The provisions of section 2357.6 shall not be operative until the Commissioner determines and publishes all of the projection factors specified in section 2355.4 and all of the totals specified in section 2357.3, at which time subdivisions (a) through (d) of this section shall cease to be operative.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

Subarticle 4. Regulation of Rates for Escrow and Subescrow Services

§ 2358.1. Scope.

The provisions of this subarticle apply to the provision of and charges for full escrow and subescrow services by a title insurance company, an underwritten title company, or a controlled escrow company for residential property transactions.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New subarticle 4 (sections 2358.1–2358.9) and section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.2. Determination of Escrow Totals.

The Commissioner shall, in consultation with the advisory organizations, determine and publish annually the calculated total and corrected total for each of the following quantities. The calculated and corrected totals are produced in the same manner with one exception — the calculated totals are produced with data as reported while the corrected totals are produced with data as corrected by the Commissioner. In the following sections, instructions for producing calculated totals are presented. The corrected totals are produced in the same manner with the exception of using corrected data, instead of reported data, in the calculation.

(a) Total full-time equivalent workers, computed as the sum of

(1) total preliminary report related full-time equivalent workers;

(2) total title insurance policy related full–time equivalent workers;
(3) total escrow related full–time equivalent workers; and
(4) total subescrow related full–time equivalent workers.
(b) Total preliminary report related full–time equivalent workers, computed as the sum of
(1) the sum of Report TI04, lines TI04.01 (Title Search/Examination), TI04.02 (Title Plant Maintenance), TI04.03 (Preliminary Report Issuance) and TI04.12 (Courier and Delivery — Preliminary Reports); Column TI04.E (Total Full–Time Equivalent Workers); and
(2) the sum of Report UTC04, lines UTC04.01 (Title Search/Examination), UTC04.02 (Title Plant Maintenance), UTC04.03 (Preliminary Report Issuance) and UTC04.12 (Courier and Delivery — Preliminary Reports); Column UTC04.E (Total Full–Time Equivalent Workers).
(c) Total title insurance policy related full–time equivalent workers, computed as the sum, for all reporting companies, of
(1) the sum of Report TI04, lines TI04.04 (Title Policy Issuance), TI04.05 (Title Claims) and TI04.13 (Courier and Delivery — Title Policy); Column TI04.E (Total Full–Time Equivalent Workers); and
(2) the sum of Report UTC04, lines UTC04.04 (Title Policy Issuance), UTC04.05 (Title Claims) and UTC04.13 (Courier and Delivery — Title Policy); Column UTC04.E (Total Full–Time Equivalent Workers).
(d) Total escrow related full–time equivalent workers, computed as the sum, for all reporting companies, of
(1) the sum of Report TI04, lines TI04.09 (Escrow Document Production and Execution), TI04.10 (Escrow Claims Settlement), TI04.11 (Recording of Documents), TI04.14 (Courier and Delivery — Escrow) and TI04.16 (Funds Transfer); Column TI04.E (Total Full–TimeEquivalent Workers); and
(2) the sum of Report UTC04, lines UTC04.09 (Escrow Document Production and Execution), UTC04.10 (Escrow Claims Settlement), UTC04.11 (Recording of Documents), UTC04.14 (Courier and Delivery — Escrow) and UTC04.16 (Funds Transfer); Column UTC04.E (Total Full–Time Equivalent Workers); less
(3) total subescrow full–time equivalent workers.
(e) Total subescrow related full–time equivalent workers, computed as the product of
(1) the sum, for all reporting companies, of
(A) the sum of Report TI04, line TI04.16 (Funds Transfer), Column TI04.E (Total Full–Time Equivalent Workers); and
(B) the sum of Report UTC.04, line UTC04.16 (Funds Transfer), Column UTC04.E (Total Full–Time Equivalent Workers);
(2) multiplied by the ratio of
(A) one–tenth of the total subescrow transactions time; to
(B) the sum of
(i) total escrow transactions; and
(ii) one–tenth of the total subescrow transactions.
(f) Total revenue, computed as the sum of
(1) total title insurance premium;
(2) total escrow charges;
(3) total subescrow charges; and
(4) total other service revenue.
(g) Total title insurance premium, computed as the sum, for all reporting companies, of Report TI03, Line TI03.1 (Gross Written Title Premium), Column TI03.D (California Current Year).
(h) Total escrow charges, computed as the sum, for all reporting companies, of
(1) Report TI03, Line TI03.04 (Escrow Fees), Column TI03.D (California Current Year); and
(2) Report UTC03, Line UTC03.04 (Escrow Fees), Column UTC03.D (California Current Year).
(i) Total subescrow charges, computed as the sum, for all reporting companies, of
(1) Report TI03, Line TI03.05 (Subescrow Fees), Column TI03.D (California Current Year); and
(2) Report UTC03, Line UTC03.05 (Subescrow Fees), Column UTC03.D (California Current Year).
(j) Total other service revenue, computed as the sum, for all reporting companies, of
(1) Report TI03, Line TI03.08 (Other Services), Column TI03.D (California Current Year); and
(2) Report UTC03, Line UTC03.08 (Other Services), Column UTC03.D (California Current Year).
(k) Total underwritten title company retained title insurance premium, computed as the sum, for all reporting companies, of Report TI03, Line TI03.12 (Title Premium Retained by or Remitted to Underwritten Title Companies), Column TI03.D (California Current Year).
(*l*) Total title insurance company retained title insurance premium, computed as the sum, for all reporting companies, of
(1) total title insurance premium, less
(2) total underwritten title company retained title insurance premium.
(m) total preliminary report related other service revenue, computed as the sum, for all reporting companies, of
(1) Report TI08, Column TI08.F (Other Service Charge) for those records in which the entry in Column TI08.F (Other Service Charge) is 1 (Preliminary Report Related); and
(2) Report UTC08, Column UTC08.F (Other Service Charge) for those records in which the entry in Column UTC08.F (Other Service Charge) is 1 (Preliminary Report Related).
(n) Total title policy issuance related other service revenue, computed as the sum, for all reporting companies, of
(1) Report TI08, Column TI08.F (Other Service Charge) for those records in which the entry in Column TI08.F (Other Service Charge) is 2 (Title Policy Issuance Related); and
(2) Report UTC08, Column UTC08.F (Other Service Charge) for those records in which the entry in Column UTC08.F (Other Service Charge) is 2 (Title Policy Issuance Related).
(o) Total escrow related other service revenue, computed as the sum, for all reporting companies, of
(1) Report TI08, Column TI08.F (Other Service Charge) for those records in which the entry in Column TI08.F (Other Service Charge) is 3 (Escrow Related); and
(2) Report UTC08, Column UTC08.F (Other Service Charge) for those records in which the entry in Column UTC08.F (Other Service Charge) is 3 (Escrow Related).
(p) Total escrow value, computed as the sum, for all reporting companies, of
(1) Report TI05, all lines (records), Column TI05.E (Amount of Escrow); and
(2) Report UTC05, all lines (records), Column UTC05.E (Amount of Escrow).
(q) Total escrow transactions, computed as the sum, for all reporting companies, of
(1) the count of records in Report TI01 in which the entry in Column TI01.D (Type of Title and Escrow Transaction) is either 1 (Title and Escrow) or 4 (Escrow Only) and the entry in Column TI01.M (Date Order Opened) is on or after the first day of the year reported in Column TI01.B (Reporting Year); and
(2) the count of all records in Report UTC01 in which the entry in Column UTC01.D (Type of Title and Escrow Transaction) is either 1 (Title and Escrow) or 4 (Escrow Only) and the entry in Column UTC01.M (Date Order Opened) is on or after the first day of the year reported in Column UTC01.B (Reporting Year).
(r) Total subescrow transactions, computed as the sum, for all reporting companies, of
(1) the count of all records in Report TI01 in which the entry in Column TI01.D (Type of Title and Escrow Transaction) is either 2 (Title and Subescrow) or 5 (Subescrow Only); and
(2) the count of all records in Report UTC01 in which the entry in Column UTC01.D (Type of Title and Escrow Transaction) is either 2 (Title and Subescrow) or 5 (Subescrow Only).
(s) Total taxes, licenses, and fees, computed as the sum, for all reporting companies, of

(1) Report TI03, lines TI03.62 (Licenses, Fees, Taxes Other Than Income and Premium), Column TI03.D (California Current Year, Report); and

(2) Report UTC03, lines UTC03.62 (Licenses, Fees, Taxes Other Than Income and Premium), Column UTC03.D (California Current Year).

(t) Total facility rent, computed as

(1) the quantity,

(A) the sum, for all reporting companies, of

(i) Report TI03, lines TI03.52 (Facility Rent, Depreciation and Amortization), Column TI03.D (California Current Year, Report); and

(ii) Report UTC03, lines UTC03.52 (Facility Rent, Depreciation and Amortization), Column UTC03.D (California Current Year);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.52 (Facility Rent, Depreciation and Amortization); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column TIUTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.52 (Facility Rent, Depreciation and Amortization);

(2) multiplied by the ratio of

(A) the sum, for all reporting companies, of

(i) total title insurance premium;

(ii) total escrow charges; and

(iii) total subescrow charges;

(B) to total operating revenue for all reporting companies.

(u) Total overhead, computed as

(1) the sum, for all reporting companies, of

(A) Report TI03, Lines TI03.46 (Messenger, Overnight and Delivery Service — Other), TI03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), TI03.53 (Equipment Rent), TI03.54 (Data Processing Services and Software), TI03.55 (Printing/Stationery/ Supplies), TI03.56 (Telephone/Utilities), TI03.57 (Postage and Freight), TI03.58 (Accounting/Auditor Fees), TI03.59 (Director Fees), TI03.60 (Legal Fees), TI03.61 (Management Fees), TI03.64 (Depreciation/ Amortization Other Than Real Estate and Buildings), TI03.65 (Bad Debt Expense), TI03.66 (Insurance), TI03.69 (Trade Associations and Advisory Organizations), TI03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations) and TI03.72 (Aggregate Write–Ins for Other Expenses), Column TI03.D (California Current Year);

(B) Report TI04, Lines TI04.06 (General Management) and TI04.15 (Courier and Delivery — Other), Column TI04.M (Total Personnel Costs);

(C) Report UTC03, Lines UTC03.46 (Messenger, Overnight and Delivery Service — Other), UTC03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), UTC03.53 (Equipment Rent), UTC03.54 (Data Processing Services and Software), UTC03.55 (Printing/Stationery/Supplies), UTC03.56 (Telephone/Utilities), UTC03.57 (Postage and Freight), UTC03.58 (Accounting/Auditor Fees), UTC03.59 (Director Fees), UTC03.60 (Legal Fees), UTC03.61 (Management Fees), UTC03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), UTC03.65 (Bad Debt Expense), UTC03.66 (Insurance), UTC03.69 (Trade Associations and Advisory Organizations), UTC03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations) andUTC03.72 (Aggregate Write–Ins for Other Expenses), Column UTC03.D (California Current Year);

(D) Report TI04, Lines TI04.06 (General Management) and TI04.15 (Courier and Delivery — Other), Column TI04.M (Total Personnel Costs);

(2) less the sum, for all reporting companies, of

(A) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.46 (Messenger, Overnight and Delivery Service — Other), TI03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), TI03.53 (Equipment Rent), TI03.54 (Data Processing Services and Software), TI03.55 (Printing/Stationery/ Supplies), TI03.56 (Telephone/Utilities), TI03.57 (Postage and Freight), TI03.58 (Accounting/Auditor Fees), TI03.59 (Director Fees), TI03.60 (Legal Fees), TI03.61 (Management Fees), TI03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), TI03.65 (Bad Debt Expense), TI03.66 (Insurance), TI03.69 (Trade Associations and Advisory Organizations), TI03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations), TI03.72 (Aggregate Write–Ins for Other Expenses) TI04.06 (General Management) or TI04.15 (Courier and Delivery — Other);

(B) Report UTC07, Column UTC07.H for all lines in which the entry in Column TIUTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.46 (Messenger, Overnight and Delivery Service — Other), UTC03.51 (Travel and Travel Items Other Than Sales, Marketing and Customer Service), UTC03.53 (Equipment Rent), UTC03.54 (Data Processing Services and Software), UTC03.55 (Printing/Stationery/Supplies), UTC03.56 (Telephone/Utilities), UTC03.57 (Postage and Freight), UTC03.58 (Accounting/Auditor Fees), UTC03.59 (Director Fees), UTC03.60 (Legal Fees), UTC03.61 (Management Fees), UTC03.64 (Depreciation/Amortization Other Than Real Estate and Buildings), UTC03.65 (Bad Debt Expense), UTC03.66 (Insurance), UTC03.69 (Trade Associations and Advisory Organizations), UTC03.70 (Dues/Subscriptions Other than Trade and Advisory Organizations), UTC03.72 (Aggregate Write–Ins for Other Expenses) UTC04.06 (General Management) or UTC04.15 (Courier and Delivery — Other).

(v) Total escrow document production and execution, computed as

(1) the quantity

(A) the sum, for all reporting companies, of

(i) Report TI03, Lines TI03.38 (Notary Fees), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.09 (Escrow Document Production and Execution), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, Lines UTC03.38 (Notary Fees), Column UTC03.D (California Current Year); and

(iv) Report UTC04, Line UTC04.09 (Escrow Document Production and Execution), Column UTC04.M (Total Personnel Costs);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.38 (Notary Fees) or TI04.09 (Escrow Document Production and Execution); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.38 (Notary Fees) or UTC04.09 (Escrow Document Production and Execution);

(2) multiplied by the ratio of

(A) total escrow charges

(B) to the sum, for all reporting companies, of

(i) total escrow charges; and

(ii) total escrow related other service revenue.

(w) Total escrow funds transfer, computed as

(1) the quantity,

(A) the sum, for all reporting companies, of

(i) Report TI03, line TI03.37 (Funds Transfer), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.16 (Funds Transfer), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, line UTC03.37 (Funds Transfer), Column UTC03.D (California Current Year); and

(iv) Report UTC04, Line UTC04.16 (Funds Transfer), Column UTC04.M (Total Personnel Costs);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.37 (Funds Transfer) or TI04.16 (Funds Transfer); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.37 (Funds Transfer) or UTC04.16 (Funds Transfer);

(2) multiplied by the ratio of

(A) total escrow transactions

(B) to the sum of

(i) total escrow transactions; and

(ii) one–tenth of total subescrow transactions.

(x) total subescrow funds transfer, computed as

(1) the quantity

(A) the sum, for all reporting companies, of

(i) Report TI03, line TI03.37 (Funds Transfer), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.16 (Funds Transfer), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, line UTC03.37 (Funds Transfer), Column UTC03.D (California Current Year); and

(iv) Report UTC04, Line UTC04.16 (Funds Transfer), Column UTC04.M (Total Personnel Costs);

(B) less the sum of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.37 (Funds Transfer) or TI04.16 (Funds Transfer); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.37 (Funds Transfer) or UTC04.16 (Funds Transfer);

(2) multiplied by the ratio of

(A) one–tenth of total subescrow transactions

(B) to the sum of

(i) total escrow transactions; and

(ii) one–tenth of total subescrow transactions.

(y) total escrow delivery and recording cost, computed as

(1) the quantity

(A) the sum, for all reporting companies, of

(i) Report TI03, Lines TI03.42 (Recording Fees and Costs) and TI03.45 (Messenger, Overnight and Delivery Services — Escrow), Column TI03.D (California Current Year);

(ii) Report TI04, Lines TI04.11 (Recording of Documents) and TI04.14 (Courier and Delivery — Escrow), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, Lines UTC03.42 (Recording Fees and Costs), UTC03.45 (Messenger, Overnight and Delivery Services — Escrow), Column UTC03.D (California Current Year); and

(iv) Report UTC04, Lines UTC04.11 (Recording of Documents) and UTC04.14 (Courier and Delivery — Escrow), Column UTC04.M (Total Personnel Costs);

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.42 (Recording Fees and Costs), TI03.45 (Messenger, Overnight and Delivery Services — Escrow); TI04.11 (Recording of Documents) or TI04.14 (Courier and Delivery — Escrow); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.42 (Recording Fees and Costs), UTC03.45 (Messenger, Overnight and Delivery Services — Escrow); UTC04.11 (Recording of Documents) or UTC04.14 (Courier and Delivery — Escrow);

(2) multiplied by the ratio of

(A) total escrow charges

(B) to the sum, for all reporting companies, of

(i) total escrow charges and

(ii) total escrow related other service revenue.

(z) Total escrow loss factor, computed as

(1) the quantity

(A) the sum, for all reporting companies, of

(i) Report TI03, Lines TI03.31 (Total Escrow Loss and Loss Settlement Expense), Column TI03.D (California Current Year);

(ii) Report TI04, Line TI04.10 (Escrow Claims Settlement), Column TI04.M (Total Personnel Costs);

(iii) Report UTC03, lines UTC03.31 (Total Escrow Loss and Loss Settlement Expense), Column UTC03.D (California Current Year); and

(iv) Report UTC04, Line UTC04.10 (Escrow Claims Settlement), Column UTC04.M (Total Personnel Costs)

(B) less the sum, for all reporting companies, of

(i) Report TI07, Column TI07.H for all lines in which the entry in Column TI07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column TI07.E is 1 (Expense) and the entry in Column TI07.G is TI03.31 (Total Escrow Loss and Loss Settlement Expense) or TI04.10 (Escrow Claims Settlement); and

(ii) Report UTC07, Column UTC07.H for all lines in which the entry in Column UTCUTC07.D is 1 (Affiliated Licensee) or 3 (Non–Affiliated Licensee), the entry in Column UTC07.E is 1 (Expense) and the entry in Column UTC07.G is UTC03.31 (Total Escrow Loss and Loss Settlement Expense) or UTC04.10 (Escrow Claims Settlement);

(2) divided by

(A) total escrow value for all reporting companies.

(aa) Federal income tax rate, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, row TI12.14 (Federal Income Tax), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) Report UTC12, row UTC12.14 (Federal Income Tax), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) Report TI12, row TI12.12 (Net Income Before Taxes), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) Report UTC12, row UTC12.12 (Net Income Before Taxes), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ab) State income tax rate, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) the sum of Report TI12, row TI12.13 (State Income Tax), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) the sum of Report UTC12, row UTC12.13 (State Income Tax), columns UTC12.B (Current Year — California), UTC12.C (First Prior

Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) the sum of Report TI12, row TI12.12 (Net Income Before Taxes), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California), and

(B) the sum of Report UTC12, row UTC12.12 (Net Income Before Taxes), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ac) Investment income yield, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, row TI12.09 (Net Investment Income), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), and

(B) Report UTC12, row UTC12.09 (Net Investment Income), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California);

(2) to the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.B (Current Year — California) and TI12.E (Third Prior Year — California);

(B) Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California);

(C) one-half of Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.B (Current Year — California) and UTC12.E (Third Prior Year — California); and

(D) Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California).

(ad) Capital gain yield, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI12, lines TI12.10 (Realized Capital Gains) and TI12.11 (Unrealized Capital Gains), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(B) Report UTC12, row UTC12.10 (Realized Capital Gains) and UTC12.11 (Unrealized Capital Gains), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum of

(A) one-half of Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.B (Current Year — California) and TI12.G (Fifth Prior Year — California);

(B) Report TI12, row TI12.27 (Total Reserves and Equity), columns TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(C) one-half of Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.B (Current Year — California) and UTC12.G (Fifth Prior Year — California); and

(D) Report UTC12, row UTC12.27 (Total Reserves and Equity), columns UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ae) Reserves to revenue ratio, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.22 (Total Reserves), columns TI12.B (Current Year — California) and TI12.G (Fifth Prior Year — California);

(B) Report TI12, row TI12.22 (Total Reserves), columns TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(C) one-half of Report UTC12, row UTC12.22 (Total Reserves), columns UTC12.B (Current Year — California) and UTC12.G (Fifth Prior Year — California); and

(D) Report UTC12, row UTC12.22 (Total Reserves), columns UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California); to

(2) the sum, for all reporting companies, of

(A) Report TI12, row TI12.06 (Total Operating Revenue), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California); and

(B) Report UTC12, row UTC12.06 (Total Operating Revenue), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(af) Net worth to revenue ratio, computed as

(1) the sum, for all reporting companies, of

(A) one-half of Report TI12, row TI12.26 (Total Equity), columns TI12.B (Current Year — California) and TI12.G (Fifth Prior Year — California);

(B) Report TI12, row TI12.26 (Total Equity), columns TI12.C (First Prior Year — California), TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(C) one-half of Report UTC12, row UTC12.26 (Total Equity), columns UTC12.B (Current Year — California) and UTC12.G (Fifth Prior Year — California); and

(D) Report UTC12, row UTC12.26 (Total Equity), columns UTC12.C (First Prior Year — California), UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California);

(2) to the sum of

(A) Report TI12, row TI12.06 (Total Operating Revenue), columns TI12.B (Current Year — California), TI12.C (First Prior Year — California) and TI12.D (Second Prior Year — California), TI12.E (Third Prior Year — California) and TI12.F (Fourth Prior Year — California);

(B) Report UTC12, row UTC12.06 (Total Operating Revenue), columns UTC12.B (Current Year — California), UTC12.C (First Prior Year — California) and UTC12.D (Second Prior Year — California), UTC12.E (Third Prior Year — California) and UTC12.F (Fourth Prior Year — California).

(ag) average escrow class relativity, computed as the ratio of

(1) the sum, for all reporting companies, of

(A) Report TI05, Column TI05.F (Basic Escrow Charge), all rows, and

(B) Report UTC05, Column UTC05.F (Basic Escrow Charge), all rows, to

(2) the sum, for all reporting companies, of

(A) Report TI05, Column TI05.L (Total Escrow Charge), all rows, and

(B) Report UTC05, Column UTC05.L (Total Escrow Charge), all rows.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.3. Determination of Projected Values for Escrow.

The Commissioner shall, in consultation with the advisory organizations, no less frequently than annually, determine and publish the following factors:

(a) the projected number of escrow transactions, consisting of the adjusted total escrow transactions multiplied by the transactions growth factor raised to the quantity the number of months between the midpoint of the historical period and the midpoint of the effective period divided by 12;

(b) the projected number of subescrow transactions, consisting of the adjusted total subescrow transactions multiplied by the transactions growth factor raised to the quantity the number of months between the midpoint of the historical period and the midpoint of the effective period divided by 12;

(c) the projected amount of escrow value, consisting of the adjusted total escrow value multiplied by the market value growth factor raised to the quantity the number of months from the midpoint of the historical period to the midpoint of the effective period divided by 12;

(d) the projected escrow document production and execution component (EsDoc), consisting of

(1) the adjusted total escrow document production and execution cost divided by

(2) the projected amount of escrow value;

(e) the projected escrow funds transfer component (EsFunds), consisting of

(1) the adjusted total escrow funds transfer cost; divided by

(2) the projected amount of escrow value;

(f) the projected subescrow funds transfer component, consisting of

(1) the corrected subescrow–related funds transfer; divided by

(2) the projected number of subescrow transactions;

(g) the projected escrow delivery and recording component (EsDeliv), consisting of

(1) the adjusted total escrow delivery and recording cost

(2) divided by the projected amount of escrow value;

(h) the projected escrow overhead component (EsOH), consisting of

(1) the adjusted total overhead, multiplied by the ratio of

(2) total escrow charges to total revenue; divided by

(3) the projected amount of escrow value;

(i) the projected subescrow overhead component (SubEsOH), consisting of

(1) the adjusted total overhead, multiplied by the ratio of

(2) total escrow charges to total revenue; divided by

(3) the projected number of subescrow transactions;

(j) the projected escrow facility rent component (EsRent), consisting of

(1) the corrected facility rent, multiplied by the ratio of

(2) total escrow related full–time equivalent workers to total full–time equivalent workers; divided by

(3) the projected number of escrow transactions;

(k) the projected subescrow facility rent component (SubEsRent), consisting of

(1) the corrected facility rent,

(2) multiplied by the ratio of total subescrow related full–time equivalent workers to total full–time equivalent workers,

(3) divided by the projected number of escrow transactions;

(l) the projected subescrow taxes licenses fees component (SubTLF), consisting of

(1) the adjusted total subescrow taxes licenses fees,

(2) divided by the projected number of subescrow transactions;

(m) the projected subescrow rent component (SubRent), consisting of

(1) the adjusted total subescrow facility rent

(2) divided by the projected number of subescrow transactions;

(n) the projected subescrow funds transfer component (SubFunds), consisting of

(1) the adjusted total subescrow funds transfer

(2) divided by the corrected number of subescrow transactions;

(o) the projected subescrow overhead component (SubOH), consisting of

(1) the adjusted total subescrow overhead

(2) divided by the corrected number of subescrow transactions.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.4. Maximum Charge for an Escrow Transaction.

The maximum escrow charge for an escrow transaction ($MaxEscrow_{trans}$) means

(a) the maximum average escrow charge ($MaxEscrow_{avg}$)

(b) divided by the average escrow relativity ($EscrowRel_{avg}$)

(c) multiplied by the escrow relativity for the transaction ($EscrowRel_{trans}$).

Stated as an equation:

$$MaxEscrow_{trans} = \frac{MaxEscrow_{avg}}{EscrowRel_{avg}} * EscrowRel_{trans}$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.5. Maximum Average Full Escrow Charge.

The maximum average full escrow charge ($MaxEs_{avg}$) means

(a) the quantity

(1) the sum of

(A) the projected escrow facility rent (EsRent) plus

(B) the projected escrow taxes, licenses and fees (EsTLF) plus

(C) the product of

(i) the transaction amount (Amt_{trans}) multiplied by the sum of

(a) the projected delivery and recording cost (EsDelRec) plus

(b) the projected escrow document production and execution component (EsDoc) plus

(c) the projected escrow funds transfer component (EsFunds) plus

(d) the projected escrow loss component (EsLoss) plus

(e) the projected escrow overhead component (EsOther)

(2) divided by

(A) 1

(B) minus the profit factor (Profit) divided by the state and federal income tax factor (SFIT)

(C) plus the investment income factor (InvInc)

(D) minus the sales factor (Sls);

(b) multiplied by the transaction escrow relativity ($EsRel_{trans}$).

Stated as an equation,

$$MaxEs_{avg} = \frac{EsRent + EsTLF + Amt_{trans} * (EsDelRec + EsDoc + EsFunds + EsLoss + EsOther)}{1 - \frac{Profit}{SFIT} + InvInc - Sls} * EsRel_{trans}$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.6. Maximum Average Subescrow Charge.

The maximum average subescrow charge ($MaxSub_{avg}$) means

(a) the quantity

(1) the sum of

(A) the projected subescrow rent (SubRent) plus

(B) the projected subescrow taxes, licenses and fees (SubTLF) plus

(C) the projected subescrow funds transfer component (SubFunds) plus

(D) the projected subescrow overhead component (Sub OH)

(2) divided by

(A) 1

(B) minus the profit factor (profit) divided by the state and federal income tax factor (SFIT)

(C) plus the investment income factor (InvInc)

(C) minus the sales factor (Sls).

Stated as an equation,

$$MaxSub_{avg} = \frac{SubRent + SubTLF + SubFunds + SubOH}{1 - \frac{Profit}{SFIT} + InvInc - Sls}$$

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.7. Escrow Relativities.

(a) "Transaction escrow relativity" means the product of all of the relativities listed in the following table that are applicable to that transaction.

Relativity for		*Relativity*
Number of parties to transaction (excluding lenders)	1	0.75
	2	1.0
	3	1.25
	4	1.5
	5	1.75
	> 5	2.0
County in which property is located	Counties having a population of 100,000 or less	1.0
	Counties having a population greater than 100,000 and less than or equal to 1,000,000	.75
	Counties having a population greater than 1,000,000 and less than or equal to 9,000,000	.5
	Counties having a population greater than 9,000,000	1.5
Refinancing	Escrow not associated with a refinancing, no change in ownership	1.0
	Escrow associated with a refinancing	0.7
Paper/Electronic	Transaction in which face–to–face meeting or exchange of paper is necessary	1.0
	Transaction in which no face–to–face meeting and no exchange of paper is necessary	0.7
Bulk order	Transaction not part of a firm commitment to provide at least 100 orders per year	1.0
	Transaction part of a firm commitment to provide at least 100 orders per year	.6

For purposes of this section, "population" shall be determined by the quantity most recently reported by the state Department of Finance.

(b) A controlled escrow company may employ any endorsement factor it chooses so long as the resulting charge for a transaction does not exceed the maximum escrow charge for that transaction pursuant to section 2358.4 and does not exceed any applicable interim maximum rate pursuant to section 2358.9.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.8. Interest–Bearing Escrow Accounts.

Where a party to an escrow timely elects to have funds it deposits placed in an interest–bearing account, a controlled escrow company may charge a fee for doing so, so long as the fee is assessed and collected pursuant to a rate filed with the Commissioner as a rate for an other service pursuant to section 2359.1 or 2359.3. Nothing in this section shall be construed to reduce or supercede any rights a consumer may have, and the failure of a consumer to elect to have his or her funds placed in an interest–bearing account shall not constitute a waiver of any rights he or she may have.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2358.9. Interim Maximum Rates for Escrow.

(a)(1) Except as provided in subdivision (e) of this section, commencing on October 1, 2010, no company may use any rate that produces charges for any escrow service that exceed the interim maximum rate for escrow (InterimMaxEscrowRate), defined as the product of

(A) the charge that the company would have charged for the same transaction type, based on rates in effect for the company on December 31, 2000 ($2000EscrowRate_{TransType}$), multiplied by:

(B) 1 plus

(i) the escrow interim rate reduction for the transaction type ($EscrowInterimReduction_{TransType,Region}$) specified in subdivision (a)(2) of this section, multiplied by

(ii) the sales price adjustment factor for the transaction type ($SPAF_{TransType,Region}$) specified in subdivision (b) of this section.

Stated as a formula, the interim maximum escrow charge effective October 1, 2010 is:

$$InterimMaxEscrowCharge = 2000EscrowRate_{TransType} * (1 + EscrowInterimReduction_{TransType,Region} * SPAF_{TransType,Region})$$

(2) The escrow interim rate reduction for the specified transaction type is defined as the value from the following table corresponding to the transaction type and region:

	Escrow Interim Rate Reduction		
	Bay Area	*South*	*Rest of State*
Escrow Purchase	–7.4%	–23.0%	–23.6%
Escrow Non–Purchase	–14.5%	–15.9%	–15.4%

(b)(1) The sales price adjustment factor is defined as follows, subject to the limitation that for a calculated amount less than or equal to 0 the value 0 shall be used and that for a calculated amount greater than 1 the value 1 shall be used:

(A) the quantity

(i) the sum of

(I) 0.9875 multiplied by 2000–2010 inflation factor (InflationFactor), defined as the change in the consumer price index series SUUR0000SA0, not seasonally adjusted from June 2000 to May 2010 multiplied by the change in this consumer price index from June 2009 to May 2010, plus

(II) 0.0125 multiplied by 2000–2010 change in transaction size (ChangeTransSize), defined as the ratio of the most current California Association of Realtors forecast of median existing single–family home sales price for 2010 to $241,350,

(ii) divided by the sum of 1 plus the quantity

(I) escrow charge/transaction factor for the type of transaction and region ($EscrowTransFactor_{TransType,Region}$), as specified, in subdivision (b)(2) of this section, multiplied by

(II) the 2000–2010 change in transaction size (ChangeTransSize)

(iii) minus 1,

(B) multiplied by the quantity

(i) 1 divided by

(ii) the escrow interim rate reduction for the transaction type (EscrowInterimReduction$_{TransType,Region}$).

Stated as a formula:

(2) The escrow charge/transaction factor for a specified transaction type and region means the value from the following table corresponding to the transaction type and region:

$$SPAF_{TransType,Region} = \left(\frac{.9875 * InflationFactor + .0125 * ChangeTransSize}{1 + (ChangeTransSize - 1) * EscrowTransFactor_{TransType,Region}} - 1 \right) * \left(\frac{1}{EscrowInterimReduction_{TransType,Region}} \right)$$

	Escrow Charge/Transaction Factor	
Region	*Escrow Purchase*	*Escrow Non–Purchase*
Bay Area	.18923	.27488
South	.39891	.29777
Rest of State	.40920	.29298

(3) The Commissioner shall publish the values of the sales price adjustment factor for escrow on or before July 30, 2010.

(c) Every company that charges for escrow services shall, no later than September 1, 2010, make a rate filing in conformance with this section covering the rates to be used on and after October 1, 2010.

(1) To the extent that a company intends to provide escrow services for which it had no filed rate on December 31, 2000, it shall identify those services in its rate filing made pursuant to this section and shall demonstrate that the rate or charge is consistent with the rate–reduction mandated by this section.

(2) If a company has filed rate reductions effective on or after January 1, 2001, and the resulting rates are no greater than the maximum interim rates as specified in subdivisions (a) and (b) of this section, the company has satisfied the rate reduction requirements of subdivisions (a) and (b) with respect to those rates. If a company has filed rate reductions effective on or after January 1, 2001, and the resulting rates are greater than the maximum interim rates as specified in subdivisions (a) and (b), the company shall further reduce rates to satisfy the requirements of subdivisions (a) and (b) with respect to those rates. If a company has not changed rates or has increased rates effective on or after January 1, 2001, the company shall reduce its rates to satisfy the requirements of subdivisions (a) and (b) of this section.

(3) Nothing in this section shall preclude a company from filing a rate at any other time, provided that the rates comply with the applicable provisions of this section and with all other applicable provisions of law. Every policy that is subject to the provisions of subdivisions (a) or (b) of this section shall be reduced to a level no greater than that prescribed in those subdivisions. Failure to reduce an existing rate on any policy or service to the level prescribed by this section shall not be excused by a greater–than–specified reduction of other rates.

(d) The rate for each service computed on the basis of the amount of insurance or computed as a percentage of the basic premium must satisfy the requirements of subdivisions (a) and (b). Each escrow company shall adjust its rates as necessary to ensure that the charge for a particular transaction does not exceed the amount the company would have charged for that transaction based on rates in effect on December 31, 2000 less the *relevant interim rate reduction percentage.*

(e) The provisions of subdivisions (a) through (d) of this section shall not become operative if the Commissioner has, by July 30, 2010, published all of the projection factors specified in section 2358.3 and all of the totals specified in section 2358.2. The provisions of section 2358.4 shall not be operative until the Commissioner determines and publishes all of the projection factors specified in section 2358.3 and all of the totals specified in section 2358.2, at which time subdivision (a) through (d) of this section shall cease to be operative.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

Subarticle 5. Enforcement

§ 2359.1. Rate Filings for Existing Rate Categories.

(a) Rate filings for title insurance policy forms, endorsements, full escrow, subescrow, discounts and surcharges established in this article and for other title insurance policy forms, endorsements, other services and other discounts and surcharges previously filed with the Commissioner shall be made, in electronic format, using the form posted on the Department of Insurance web site, www.insurance.ca.gov. The filing shall include

(1) a narrative description of any rate changes, including the effective date of new rates,

(2) a table listing rates for preliminary reports, policy forms, endorsements, escrow, subescrow, other services, discounts and surcharges,

(3) a complete rate manual, including a complete set of base rates, with rate changes highlighted, and a complete description of any criteria for a consumer's eligibility for a policy form, endorsement, escrow, other service, or discount and any criteria for the application of any surcharge. The absence of any stated criteria in the rate manual means that any consumer is eligible for the policy form, endorsement, escrow, other service or discount. Eligibility criteria must describe and include objective characteristics of the consumer and real estate transaction, must be sufficiently descriptive to ensure certainty about a consumer's eligibility and must be applied consistently and objectively for all consumers.

(b) Within 15 days of receipt of a filing, the Department shall notify the filing company of any deficiencies in the filing that cause the filing to be incomplete. An incomplete filing is not a valid filing, and the rates in an incomplete filing may not be used by the filing company. If the Department has not notified the filing company that the filing is incomplete within 15 days of receipt of the filing by the Department, the filing is deemed complete. Any notice by the Department to the filing company of deficiencies with a filing shall include a specific statement of the deficiencies.

(c) A copy of all filings shall be made available to the public at designated Department of Insurance offices.

(d) Within 60 days of the Commissioner's initial publication of data reported pursuant to the statistical plan and annual financial reporting requirements of subarticle 2, each company licensed to engage in the business of title insurance shall make a filing pursuant to this section.

(e) Each rate filing shall specify the date on which the filing entity intends for the filing to become effective. The entity shall commence use of the filed rates on the effective date, without any affirmative approval by the Commissioner.

(f) The effective date of a rate filing may be no earlier than the date of filing with the Commissioner.

(g) The effective date of a rate filing may be no earlier than 30 days from the date of filing with the Commissioner if the filing contains a rate increase. A filing contains a rate increase if one or more rates or charges increase from current rates and charges.

(h) The schedules of rates of every title insurer, underwritten title company, or controlled escrow company and a description of the nature of unusual risks, coverages, or services for which charges in excess of those set forth in its schedules of rates may be made pursuant to the provisions of Section 12401.8 of the Insurance Code shall be printed or typed in type not smaller than 10– point and shall be prominently displayed in a public place in each office of a title insurer, underwritten title company, or a controlled escrow company in the county to which such rates or charges apply. Such schedules and material shall be displayed for a period of not

less than 30 days prior to their effective date, shall continue to be displayed so long as they remain in effect, and, on request, copies of such schedules and material or adequate summaries of the pertinent part or parts thereof shall be furnished to the public.

(i) A title insurer which is a member of an organization qualified to conduct operations as an advisory organization pursuant to Article 5.7 of Chapter 1, Part 6, Division 2 of the Insurance Code and which has adopted for its own use the forms of title policies and endorsements prepared by such organization may authorize the advisory organization to file such forms on its behalf with the Insurance Commissioner providing authorization to accept such agency filing is given in writing to the Insurance Commissioner. Such written authorization executed by the title insurer must be submitted to the advisory organization which shall then transmit a copy to the Insurance Commissioner.

(j) Where a filing by an underwritten title company includes all or a part of the schedule of rates of a title insurer whose policies of title insurance the underwritten title company is authorized by an underwriting contract to issue, the filing shall identify the title insurer by name as the source of such rates included in the filing. In lieu of the actual inclusion of the rates of the title insurer in its filing, an underwritten title company may incorporate such rates by reference. The incorporation by reference of the title insurer's filed rates shall be by written statement which shall identify the title insurer and all those rates of the title insurer that have been adopted by the underwritten title company as its own. In the event the underwritten title company intends to be bound by all subsequent changes thereafter made by the title insurer in the rates thus incorporated by reference, a written statement clearly expressing the underwritten title company's intention to be so bound must be on file with the Commissioner to enable the incorporation by reference to provide prospective compliance with this section. When such a statement is on file, any new or revised rate filing made by the title insurer shall be deemed to be incorporated by reference in the underwritten title company's rate filing. The filing by the underwritten title company must, however, directly include a copy of the underwriting contract between the underwritten title company and the title insurer whose policies of title insurance the underwritten title company is authorized to issue. The underwritten title company must also file all amendments, when made, to its underwriting contract with a title insurer.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1, 12401.2, 12401.7, 12401.8 and 12401.9, Insurance Code.

HISTORY

1. New subarticle 5 (sections 2359.1–2359.7) and section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2359.2. Charges in Excess of Maximum Rates.

(a) Any preliminary report charge, title insurance premium, escrow charge or subescrow charge in excess of the maximum permitted title premium or charge is deemed to be an excessive rate for purposes of Insurance Code Section 12401.3.

(b) The charging of any title insurance premium in excess of the maximum permitted title premium, or the charging of any rate in excess of the maximum permitted escrow charge, shall be deemed a willful violation if the insurer, underwritten title company, or controlled escrow company fails to make a new rate filing to reduce the premium or rate and fails to refund any excessive premium or charge paid during the period the rates were in use, in the manner provided in subsection (c) below, after receipt of any of the following:

(1) a notice to correct noncompliance issued pursuant to Insurance Code Section 12414.14, which shall include the identification of all rates or charges that are excessive and the Department's calculation of the maximum rate or charge to demonstrate why the company's rates are excessive,

(2) a notice of public hearing issued pursuant to Insurance Code Section 12414.15, which shall include the identification of all rates or charges that are excessive and the Department's calculation of the maximum rate or charge to demonstrate why the company's rates are excessive, or

(3) an order finding a rate violation pursuant to Insurance Code Section 12414.16, which shall include the identification of all rates or charges that are excessive and the Department's calculation of the maximum rate or charge to demonstrate why the company's rates are excessive.

(c) An insurer, underwritten title company or controlled escrow company shall qualify for an affirmative defense to an allegation of willfulness if the excessive premium or charge collected is returned to the overcharged party as follows:

(1) Within 30 days after receipt of a notice or order described in subsection (b) above, the recipient of such notice or order submits a complete rate filing in which no rate or charge exceeds the maximum permitted by the relevant provision of article 7.1, subarticles 3 and 4.

(2) Within 30 days of the effective date of the rate filing provided in (c)(1) above, the insurer, underwritten title company or controlled escrow company shall issue to each consumer who was overcharged an amount equal to the difference between the amount charged and the amount that would have been charged if the filing in (c)(1) had been in effect. In addition to this amount, the insurer, underwritten title company or controlled escrow company shall issue to the consumer interest on the overcharge in an amount equal to the average rate during the period the excessive rates were in effect of a United States Government ten–year bond per annum. The interest on the overcharge shall be issued to the consumer for the period from the date of original purchase to the date the restitution is paid.

(3) Within 30 days of the effective date of the filing in subsection (c)(1) above, the insurer, underwritten title company or controlled escrow company shall submit to the Commissioner a report listing each payment, including the name of the consumer, the date of original purchase, the amount of overcharge, the amount of interest and the total amount paid to the consumer.

(d) Nothing in this article shall preclude a charge less than the maximum title insurance or escrow charge. Companies are free to charge any rate that does not exceed the maximum charge so long as that rate is not inadequate, unfairly discriminatory, or otherwise in violation of the law.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1, 12401.2, 12414.14, 12414.15 and 12414.16, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2359.3. Filings for New Policy Forms, Endorsements, Other Services, Discounts, and Surcharges.

(a) A company seeking to use a new policy form, endorsement, other service, discount or surcharge shall make a filing with the Commissioner prior to the use of the new policy form, endorsement, other service, discount or surcharge that includes the following information:

(1) a narrative description of the form, endorsement, other service, discount or surcharge proposed, including

(A) a complete description of the product or service,

(B) a detailed explanation of how the proposed form, endorsement, other service, discount or surcharge differs from existing forms, endorsements, other services, discounts or surcharges, and

(C) a list of all eligibility criteria proposed for use with the new policy form, endorsement, other service, discount or surcharge;

(2) a proposed effective date that shall be no sooner than 30 days after receipt of the filing by the Department;

(3) a copy of any proposed policy form or endorsement;

(4) a copy of the proposed rate manual pages for the policy form, endorsement, other service, discount or surcharge, including all eligibility criteria proposed for use with the new policy form, endorsement, other service, discount or surcharge; and

(5) an analysis justifying the proposed rates or charges, pursuant to subsections (c), (d) and (e), below.

(b) A new discount or surcharge shall be a subset of an existing rate category, and the rate for the discount or surcharge shall not exceed the rate for the rate category of which the proposed discount or surcharge is a subset.

(c) The proposed rate for a new policy form or endorsement must be justified with an economic and actuarial analysis that

(1) identifies the policy form listed in section 2357.17 or the endorsement listed in section 2357.18 that the title insurer claims to have the expected losses and costs most closely equaling the new policy form; and

(2) demonstrates the difference between the rate for the policy form or endorsement identified in subdivision (c)(1) of this section and the proposed rate for the new policy form or endorsement is justified by specified differences in expected losses and costs and the proposed rate is reasonable and not excessive in relation to expected risk and costs. For purposes of this section, expected differences in profits or sales costs (including customer service costs) may not be taken into account in justifying a different relativity.

(d) The proposed rate for a new policy form or endorsement must be justified with an economic analysis that demonstrates the proposed rate is reasonable and not excessive in relation to the costs of providing the new policy form or endorsement. For purposes of this section, the analysis shall demonstrate that the provisions for profit, federal income tax, investment income, and sales cost shall be no greater than permissible for a policy charge pursuant to the provisions of section 2357.13, effective on the date the proposed rate for the new policy form or endorsement was filed.

(e) The proposed rates for a new discount or surcharge must be justified with an economic and actuarial analysis that establishes the amount of the discount or surcharge is reasonable in relation to expected differences in risk or costs of the proposed risk classification. For purposes of this section, expected differences in profits or sales costs (including customer service costs) may not be taken into account in justifying a different relativity.

(f) Within 15 days of receipt of a filing for a new policy form, endorsement, other service, discount, or surcharge, the Department shall notify the filing company of any deficiencies in the filing that cause the filing to be incomplete. Where the Department has given such notice, the filing is not effective to permit the company to charge the rates contained in the filing. If the Department has not notified the filing company that the filing is incomplete within 15 days of receipt of the filing by the Department, the filing is deemed complete. Any notice by the Department to the filing company of deficiencies with a filing shall include a specific statement of the deficiencies.

(g) Within 30 days of the receipt of a complete filing, the Department shall disapprove the filing if

(1) the proposed other service, discount, or surcharge is not materially different from an existing product, service, discount, or surcharge or if the proposed other service is for activities already included in the provision of a preliminary report, title policy, full escrow or subescrow,

(2) the proposed rate is excessive in relation to the reasonable costs of providing the proposed product or service, or

(3) the filing is otherwise in violation of law.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1, 12401.2 and 12401.7, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2359.4. Disclosure to Consumer of Available Discounts.

Each policy and closing statement shall be accompanied by a form enumerating each discount available under the rate filing and a notation indicating whether the consumer was or was not afforded the discount. A copy of the form shall be retained by the company for a period of three years. Neither provision nor acceptance of the form shall constitute waiver of the consumer's right to be charged the filed rate.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2359.5. Regulation of Charges for Unusual Risks or Unusual Services.

(a) A title insurance company, underwritten title company, or controlled escrow company may impose a charge for an unusual risk or an unusual service if

(1) the charge is reasonably commensurate with the risks assumed for an unusual risk or the cost of the service performed for an unusual service, as demonstrated pursuant to subsection (b) of this section,

(2) the charge is disclosed to the person asked to pay the charge using the form specified in subsection (d) of this section no later than the earlier of

(A) the time of the delivery of the preliminary report, or

(B) 15 days before closing of the real estate transaction, and

(3) the person asked to pay the charge agrees to do so by executing the consent specified in subsection (d) of this section.

(b) A charge for an unusual risk is reasonably commensurate with the risks assumed if the charge accurately reflects the expected cost of additional coverage as demonstrated by an actuarial and economic analysis. For purposes of this section, the analysis shall demonstrate that the provisions for profit, federal income tax, investment income, and sales cost shall be no greater than permissible for a policy charge pursuant to the provisions of section 2357.13, effective on the date the proposed rate for the new policy form or endorsement was filed.

(c) A charge for an unusual service is reasonably commensurate with the cost of services provided if the charge accurately reflects the costs of the service as demonstrated by an actuarial and economic analysis. For purposes of this section, the analysis shall demonstrate that the provisions for profit, federal and state income tax, investment income, and sales cost shall be no greater than permissible for a preliminary report charge pursuant to the provisions of section 2357.7, effective on the date the proposed rate for the new policy form or endorsement was filed.

(d) The disclosure of a proposed charge for an unusual risk or unusual service shall be presented on a separate piece of paper sized 8 1/2 inches by 11 inches, and the text of the disclosure shall be no smaller than 12–point type. The disclosure shall state the following, with bolded and capitalized text as indicated:

DISCLOSURE of and CONSENT
for PROPOSED EXCESS CHARGE

You are being asked to pay an excess charge beyond the standard charge for an unusual risk or unusual service.

Description Of Unusual Risk Or Unusual Service:

[Title insurance company, underwritten title company or controlled escrow company provides a description of the risk or service]

Amount of Excess Charge:

[Title insurance company, underwritten title company or controlled escrow company enters the dollar amount of the proposed charge.]

Date Disclosure Provided to Consumer:

[Title insurance company, underwritten title company or controlled escrow company enters the date the disclosure was provided to the consumer.]

Do not sign this disclosure and consent form unless all of the following are stated above:

A complete description of the proposed unusual risk or unusual service, the proposed charge, the date you received the disclosure.

Do not sign this disclosure and consent form unless you received the disclosure no later than the earlier of the delivery of the preliminary report or 15 days prior to closing; and you believe the cost is reasonable.

You are not required to accept the excess charge. However, the title insurance company, underwritten title company or controlled escrow company may decline your business if you do not accept the charge. The Insurance Commissioner encourages you to shop around if you feel the excess charge is unreasonable.

The proposed charge for the unusual risk or unusual service must be commensurate with the costs of providing the additional coverage or the additional service. The proposed unusual risk may not be a coverage already included in the proposed title policy. The proposed unusual service may not be a service included in standard escrow or other services filed with the Department of Insurance, a list of which is available for your review.

Name of Consumer:

Address of Property That is Subject of Title or Escrow:

Name of Title Insurance Company, Undewritten Title Company or Controlled Escrow Company Proposing the Excess Charge:

I accept the excess charge described above.

Signature: Date:

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1, 12401.2 and 12401.8, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2359.6. Hearings on Rates and Charges.

(a) This section applies to any hearing on a company's rates or charges pursuant to Insurance Code Sections 12414.13–12414.18.

(b) The hearing shall be for the purpose of determining whether

(1) the premium, rate, or charge at issue exceeds the maximum permitted rate or charge calculated pursuant to subarticle 3 or subarticle 4 of this article; or

(2) the premium, rate, or charge at issue is inadequate, unfairly discriminatory, or otherwise in violation of the law.

(c) In a hearing on an insurer's rates or charges, relitigation of a matter already determined by these regulations is out of order and shall not be permitted.

(d) In a hearing in which suspension or revocation of a company's license or certificate of authority is at issue, the hearing shall be governed by chapter 5 of part 1 of division 3 of title 2 of the Government Code. In all other hearings conducted pursuant to this article, the procedures shall be determined by the Administrative Law Judge in accordance with article 1 of subchapter 4.5 of this title of the Code of California Regulations.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5 and 12414.21, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1, 12401.2 and 12401.13–12414.18, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2359.7. Rating Examinations.

The Commissioner may, as often as may be reasonable and necessary to assure compliance with the standards and requirements of Article 5.5 and Article 7.1 of Chapter 1, Part 6, Division 2 of the Insurance Code and with such other provisions of the Insurance Code as relate to the business of title insurance, examine every advisory organization, title insurer, underwritten title company or controlled escrow company. Such examination of a title insurer, underwritten title company, or controlled escrow company may include a review of the books, records, accounts, rates, charges, fees, rating plans, rating systems, underwriting rules or policy forms adopted and used by such person or entity and the loss or expense experience and the data, statistics, or information collected or used by it in determining or establishing the rates, charges, fees, rating plans, rating systems, underwriting rules or policy forms which it has adopted and uses. Such examination may include a review of the statistical plan and financial data reports submitted pursuant to subarticle 2. Such examination shall not be a part of a periodic general examination participated in by a representative of more than one state.

NOTE: Authority cited: Sections 12389, 12397.5, 12401.3, 12401.5, 12414.21 and 12407, Insurance Code; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 12401.1 and 12401.2, Insurance Code.

HISTORY

1. New section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

Article 7.2. Objective Guidelines for Rating; Lowest Rates; Rates Charged by Insurers Which Are Members of a Group; Documentation; Upgrades.

§ 2360.0. Definitions.

As used in these sections:

(a) An "Insurer Group" is any two or more insurers which exercise any authority granted in CIC Section 1853.5.

(b) "Eligibility Guidelines" are specific, objective factors, or categories of specific, objective factors, which are selected and/or defined by an insurer, and which have a substantial relationship to an insured's loss exposure.

(c) The term "Premium" shall mean the final amount charged to an insured for insurance after applying all applicable rates, factors, modifiers, credits, debits, discounts, surcharges, fees charged by the insurer and all other items which change the amount the insurer charges to the insured.

(d) A "Rating Plan" is any rating plan, rating system, or method, used by an insurer to develop a final rate or Premium.

(e) An "Insurance Marketing System" is a method of producing or selling insurance. For purposes of this Article there are only three types of Insurance Marketing Systems: (1) marketing through exclusive or captive agents; (2) marketing through independent agents and brokers; and (3) direct marketing by an insurer or non–agent employee of an insurer.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1857, 1861.05, Insurance Code.

HISTORY

1. New article 7.2 and section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Editorial correction of subsection (e) (Register 96, No. 9).
3. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.1. Subject Lines of Insurance.

This article shall apply to all lines of insurance except those which are listed in California Insurance Code (CIC) Section 1851(a) through (h).

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1851, 1857, 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.2. Eligibility Guidelines / Qualification for Insurance and Rating Plan.

An insurer shall maintain eligibility guidelines for every line of insurance offered for sale to the public. The Eligibility Guidelines shall be sufficiently detailed to determine the appropriate rating plan for the insured. An insured or applicant who meets the eligibility guidelines shall qualify to purchase the insurance.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1857, 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.3. Lowest Premium.

An insurer shall charge each insured the lowest Premium for which the insured qualifies. At each policy renewal the insurer shall adjust the Pre-

mium charged to the insured, as necessary, to reflect the lowest Premium for which the insured qualifies at that time.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.4. Insurer to Determine Lowest Premium.

It shall be the responsibility of the insurer to determine the lowest Premium for which an insured qualifies in accordance with this chapter. If the insurer delegates this responsibility to an agent, the insurer shall remain responsible for the agent's determination. This responsibility shall not be delegated to the insured's broker.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.5. Rates Charged by Insurers in Insurer Group.

Any two or more insurers which are members of an insurer group and which use the same type of Insurance Marketing System and which maintain the same eligibility guidelines for the same or substantially similar insurance, shall place the insured with the company in the group which would charge the insured the lowest Premium. If two or more insurers in the same insurer group use the same type of Insurance Marketing System but apply different rating plans for the same or substantially similar insurance, each insurer shall maintain mutually exclusive eligibility guidelines for the insurance.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.6. Documentation Supporting Rates.

The insurer shall keep documentation in the underwriting file for every insurance policy issued to every insured, identifying all information which the insurer considered in determining the Premium charged to the insured. This documentation shall be maintained at all times during which a policy is in force and for at least three years from the policy inception date.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1857, 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2360.7. Upgrades.

Whenever an insurer makes insurance with broadened or enhanced coverage available to new insureds, the insurer shall offer the same broadened or enhanced coverage to all existing insureds which otherwise qualify for the newly broadened or enhanced coverage, and the insurer shall apply the same rating plans to both new and existing insureds in accordance with this chapter. Any change in coverage offered to existing insureds under this section shall be offered no later than the next renewal date.

NOTE: Authority cited: Sections 1861.05, 12921, and 12926, Insurance Code. Reference: Sections 1861.05, 1861.135(a), 1861.137(b), 11588, 12120, 12122, and 12713, Insurance Code.

HISTORY

1. New section filed 12–12–95; operative 1–11–96 (Register 95, No. 50).
2. Change without regulatory effect adding new NOTE filed 2–27–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 9).

§ 2361. Consideration of Losses and Loss Exposure in Residential Property Insurance Rating and Underwriting.

NOTE: Authority cited: Sections 679.71, 791.02, 791.12, 1857, 1857.2, 1857.3, 1857.7, 1857.9, 1861.05 and 12926, Insurance Code. Reference: Sections 675, 676, Article 6.5, 790 et seq., 791.10(a), 1861.03 and 12926, Insurance Code.

HISTORY

1. New section filed 7–21–2003 as an emergency; operative 7–21–2003 (Register 2003, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–18–2003 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 11–18–2003 as an emergency; operative 11–18–2003 (Register 2003, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–17–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–15–2004 as an emergency; operative 3–16–2004 (Register 2004, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–14–2004 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 7–12–2004 as an emergency; operative 7–12–2004 (Register 2004, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–9–2004 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2004, No. 47).
6. New section filed 11–19–2004 as an emergency; operative 11–19–2004 (Register 2004, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–21–2005 or emergency language will be repealed by operation of law on the following day.
7. Repealed by operation of Government Code section 11346.1(g) (Register 2005, No. 15).

Article 7.3. Slavery Era Insurance Policies Registry

§ 2393. Purpose.

These regulations establish standards for reporting under the Slavery Era Insurance Policies statute. California Insurance Code Sections 13810, 13811, 13812 and 13813 became effective on January 1, 2001 and require insurers to provide certain information and data to the California Department of Insurance and direct the Department to provide public access to the data.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 13810, 13811, 13812 and 13813, Insurance Code.

HISTORY

1. New article 7.3 (sections 2393–2398) and section 9–13–2001; operative 10–13–2001 (Register 2001, No. 37).

§ 2394. Definitions.

(a) The term "insurer" means any insurer licensed and doing business in California on or after January 1, 2001.

(b) The term "predecessor corporation" means a corporation in the reporting insurer's family tree that existed prior in time to the reporting corporation.

(c) The term "reporting insurer", means an insurer which has been designated by its holding company to submit a consolidated report which is responsive to these regulations.

(d) The term "slave" means a person wholly subject to the will of another, having no freedom of action and whose person and services were wholly under the control of another, and who was in a state of enforced compulsory service to another.

(e) The term "slaveholder" means owners of slaves; owners of business enterprises using slaves; owners of slave–carrying vessels or other means of transporting slaves; merchants and/or financiers dealing in the purchase, sale, or financing of the business of slaves and slavery; slave dealers and slave brokers.

(f) The term "slaveholder insurance policies" means policies issued to or for the benefit of slaveholders to insure then against the death of, or injury to, human property.

(g) The term "slavery era" means prior to 1865.

NOTE: Authority cited: Section 12921(a), Insurance Code. Reference: Sections 1215(f), 13810(e), 13811, 13812 and 13813, Insurance Code.

HISTORY
1. New section 9–13–2001; operative 10–13–2001 (Register 2001, No. 37).

§ 2395. Who Is Required to Submit a Report.

(a) Every insurer must report to the Commissioner regarding slaveholder insurance policies that it wrote either directly or through a predecessor corporation during the slavery era.

(b) A consolidated report may be submitted by the reporting insurer's holding company on behalf of all members of the holding company required to file a report. A consolidated report shall designate one insurer as the reporting insurer for purposes of compliance with CCR Title 10, Sections 2393 through 2398 and shall specify which insurers are included in the report. Insurers choosing to file a consolidated report must comply with all other requirements of these regulations.

NOTE: Authority cited: Section 12921(a), Insurance Code. Reference: Sections 13810, 13811, 13812 and 13813, Insurance Code.

HISTORY
1. New section 9–13–2001; operative 10–13–2001 (Register 2001, No. 37).

§ 2396. Report Format.

(a) The report shall be submitted on letterhead of the reporting insurer, dated, signed and verified as provided in California Code of Regulations, Title 10, Sections 2683.22, by an officer of the insurer who has the authority to bind the insurer (this person shall be the contact person for the purpose of implementing these regulations), with paragraphs numbered as follows:

(1) Insurer Identification

This paragraph shall state the name, address, telephone number, fax number, e–mail address, NAIC number and website URL, if any, for the main office of the insurer making the report.

(2) Contact Person

This paragraph shall state the name, address, telephone number, fax number and e–mail address for the insurer's Contact Person as set forth in California Code of Regulations Title 10 Section 2278.3(a).

(3) Research methodology

This section of the report shall contain the following information:

A description of the report shall contain the following information:

A description of the methods employed by the insurer to identify and compile the records and information that are responsive to this regulation. This section shall include a description of the research which was conducted at the insurer's own facility as well as a description of research which was conducted at other facilities known to the insurer, if any. If the insurer has found no data responsive to this statute, it shall so state.

(4) Names of Slaves:

The insurers shall submit information regarding the names of slaves alphabetically as follows: last name, first name, name of slaveholder, beneficiary and/or policyholder, county (or parish), state, any other identifying information. It is the insurers' responsibility to compile the information required herein.

(5) Names of Slaveholders:

The insurers shall submit the information regarding the names of slaveholders alphabetically as follows: last name, first name, county (or parish), state, any other identifying information. It is the insurers' responsibility to compile the information required herein.

(6) Policy information:

The insurer shall provide copies of all records and documents regarding insurance policies issued to slaveholders that provided coverage for damage to or death of slaves. If these records are in any language other than English, the insurer shall provide a copy of the document together with a certified translation.

(b) Reports shall be submitted on paper (an original plus one copy). The sections of the reports outlined in 2396(a)(4) and (a)(5) shall also be submitted in the electronic format approved by the Commissioner. The electronic format (Circular SEIR–2001 rev. 7/20/01) is available on the Department's website at www.insurance.ca.gov. Reports shall be mailed to the Department of Insurance at the address listed below. Faxed reports will not be accepted.

SLAVERY ERA INSURANCE REGISTRY
CALIFORNIA DEPARTMENT OF INSURANCE
45 FREMONT STREET, 21ST FLOOR
SAN FRANCISCO, CALIFORNIA 94105

NOTE: Authority cited: Section 12921(a), Insurance Code. Reference: Sections 13810, 13811, 13812 and 13813, Insurance Code.

HISTORY
1. New section 9–13–2001; operative 10–13–2001 (Register 2001, No. 37).

§ 2397. Time for Submission.

The report shall be received at the Department on or before October 15, 2001. If the Commissioner determines that a report is incomplete, the Commissioner may require additional reports, as necessary, consistent with the requirements of Sections 13810, 13811, 13812 and 13813, Insurance Code and these regulations.

Any insurer that submits a report indicating that it has information responsive to the relevant statute and these regulations which has not been provided, must inform the Department as to the reason that the required information has not been provided and when the required information will be submitted. Insurers that fail to submit all of the information required herein on or before October 15, 2001 must submit progress reports on the first day of every month thereafter until the required information has been submitted. The required information shall be submitted no later than December 14, 2001. The progress reports shall contain an updated research methodology as required in section 2396(a)(3) of these regulations.

NOTE: Authority cited: Section 12921, Insurance Code. Reference: Sections 13810, 13811 and 13812, Insurance Code.

HISTORY
1. New section 9–13–2001; operative 10–13–2001 (Register 2001, No. 37).

§ 2398. Establishment of the Slavery Era Insurance Policy Registry.

Pursuant to California Insurance Code Section 13811, the Department shall establish and report to the Legislature and make available to the public, all information received from insurers pursuant to California Insurance Code Sections 13810, 13811, 13812 and 13813 and these regulations. The lists of names of slaves and names of slaveholders and other slavery era insurance policy information shall be known as the Slavery Era Insurance Policy Registry and shall be accessible to the public at the Department's Public Viewing Rooms in Los Angeles and in San Francisco and/or pursuant to any other means as the Commissioner shall deem appropriate.

NOTE: Authority cited: Section 12921(a), Insurance Code. Reference: Sections 13810, 13811, 13812 and 13813, Insurance Code.

HISTORY
1. New section 9–13–2001; operative 10–13–2001 (Register 2001, No. 37).

Article 7.5. Automobile Insurance Cancellations—Grounds and Appeals

NOTE: Authority cited: Sections 660–664, Insurance Code. Reference: Sections 660–669.5, Insurance Code.

HISTORY
1. Repealer of Article 7.5 (Sections 2370 through 2373) filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19). For prior history, see Registers 65, No. 17, and 66, No. 1.

Article 8. California Automobile Assigned Risk Plan

§ 2400. Purpose and Scope.

NOTE: Authority cited for §§ 2400 to 2498, inclusive: Section 11620, Insurance code.

HISTORY
1. New §§2400 to 2498, inclusive, filed 12–17–47 designated to be effective 1–19–48 (Register 10, No. 7).
2. Amendment filed 6–24–57; designated effective 8–15–57 (Register 57, No. 10).
3. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2401. Short Title.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2402. Effective Date.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624, Insurance Code.

HISTORY

1. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
2. Repealer filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).

§ 2403. Terms Defined.

HISTORY

1. Amendment filed 5–10–60; designated effective 7–1–60, and with respect to all policies, both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on or after July 1, 1960 (Register 60, No. 12).
2. Amendment filed 6–28–63; designated effective 8–1–63 (Register 63, No. 11).
3. New subsection (g) filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
4. New subsection (h) filed 6–4–76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).
5. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2404. To Whom Available.

HISTORY

1. Amendment filed 7–29–53; effective thirtieth day thereafter (Register 53, No. 13).
2. Amendment filed 2–15–62; designated effective 4–1–62 (Register 62, No. 3).
3. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2405. Admitted Liability Insurers Shall Participate.

HISTORY

1. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

[The next page is 605.]

§ 2406. Amount of Coverage.

HISTORY

1. Amendment filed 10–10–51; effective thirtieth day thereafter (Register 26, No. 1).
2. Amendment filed 5–10–60; designated effective 7–1–60, and with respect to all policies, both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after July 1, 1960 (Register 60, No. 12).
3. Amendment filed 12–15–67 as an emergency; designated effective 1–1–68 (Register 67, No. 50).
4. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
5. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2407. Standard Coverage to Be Afforded.

NOTE: Authority cited: Section 11624(d), Insurance Code. Reference: Sections 11622 and 11624, Insurance Code.

HISTORY

1. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
2. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
3. Amendment filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
4. Amendment of subsection (b) filed 10–18–79; designated effective 1–1–80 (Register 79, No. 42).
5. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
6. Amendment filed 4–26–84; effective thirtieth day thereafter (Register 84, No. 17).
7. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2408. Uninsured Motorist Protection.

HISTORY

1. New section filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2420. Governing Committee and Manager: Location of Offices.

HISTORY

1. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421. Governing Committee: Membership and Groups Represented.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11623 and 11624, Insurance Code.

HISTORY

1. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40). For prior history, see Register 72, No. 14.
2. Amendment filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
3. Amendment of subsection (d) filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).
4. Amendment filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
5. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.1. Same. Election of Members.

HISTORY

1. New subsection (d) filed 2–15–62; designated effective 4–1–62 (Register 62, No. 3).
2. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2421.1a. Meetings, Time and General Purposes.

HISTORY

1. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.2. Selection of Manager; Determination of Employees' Compensation.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.3. Same: Authority; Records.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.4. Budget; Assessments; Funds.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.5. Disbursements.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.6. Designation of Disbursing Agents; Surety Bond Requirements.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.7. Records and Reports.

HISTORY

1. Repealer filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).

§ 2421.8. Faithful Performance of Duties.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.9. Amendments to Plan.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2421.10. Annual Review of Surcharges.

HISTORY

1. New section filed 5–10–60; designated effective July 1, 1960, and with respect to all policies, both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after July 1, 1960 (Register 60, No. 12).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2422. Manager: Appointment and Duties.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2430. To Whom Restricted: Applicant's Eligibility.

NOTE: Authority cited: Section 11620, Insurance Code. Reference Sections 11620–11627, Insurance Code.

HISTORY

1. Repealer of subsection (c) filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27). For prior history, see Register 76, No. 23.
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2431. Eligibility: Exclusion of Named Driver.

HISTORY

1. New section filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27). For former section see Register 71, No. 14.
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2431.1. Producer Certification and Decertification.

NOTE: Authority cited: Sections 11620, 11623 and 11624, California Insurance Code. Reference: Sections 11622.5, 11623 and 11624, California Insurance Code.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Amendment filed 5–10–60; designated effective 7–1–60 (Register 60, No. 12).
3. Repealer filed 6–28–63; designated effective 8–1–63 (Register 63, No. 11).
4. New section filed 11–28–95; operative 12–28–95 (Register 95, No. 48). For prior histories of sections 2431.1 and 2431.2, see Register 63, No. 11; for prior histories of sections 2431.1a, 2431.2a, 2431.3, 2431.3a, 2431.4, 2431.4a, 2431.5, 2431.5a, 2431.6, 2431.6a, 2431.7, 2431.8, 2431.8a, 2431.9, 2431.10 and 2431.11, see Register 71, No. 14; for prior history of section 2431.7a see Register 60, No. 12.

5. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2431.2. Producer Performance Standards.

NOTE: Authority cited: Sections 11620, 11623 and 11624, California Insurance Code. Reference: Sections 11622.5, 11623 and 11624, California Insurance Code.

HISTORY

1. New section filed 11–28–95; operative 12–28–95 (Register 95, No. 48). For prior history see Register 63, No. 11.
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2431.3. Insurer Performance Standards.

NOTE: Authority cited: Sections 11620, 11623 and 11624, California Insurance Code. Reference: Sections 11624.1, 11624.2, 11624.3, 11624.4 and 11624.7, California Insurance Code.

HISTORY

1. New section and forms filed 11–28–95; operative 12–28–95 (Register 95, No. 48). For prior history see Register 71, No. 14.
2. Repealer of section and forms filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2432. Commercial Automobile Insurance Procedure.

NOTE: Authority cited: Section 11624(d), Insurance Code. Reference: Sections 11622 and 11624, Insurance Code.

HISTORY

1. New section filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45). For history of former Section 2432, see Register 71, No. 14 and 57, No. 10.
2. Repealer and new section filed 4–26–84; effective 30th day thereafter (Register 84, No. 17).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2433. Performance Standards for Servicing Carriers.

NOTE: Authority cited: Section 11620, Government Code. Reference: Sections 11620–11627, Government Code.

HISTORY

1. New section filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45). For history of former Section 2433, see Register 71, No. 14.
2. Repealer filed 4–26–84; effective thirtieth day thereafter (Register 84, No. 17).

§ 2434. Duties and Responsibilities of Servicing Carriers and Central Processor.

NOTE: Authority cited: Section 11620, Government Code. Reference: Sections 11620–11627, Government Code.

HISTORY

1. New section filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45). For history of former Section 2434, see Register 71, No. 14.
2. Repealer filed 4–26–84; effective thirtieth day thereafter (Register 84, No. 17).

§ 2435. Special Risk Distribution Procedure.

NOTE: Authority cited: Section 11620, California Insurance Code. Reference: Sections 11620–11627, California Insurance Code.

HISTORY

1. New section filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45). For history of former Section 2435, see Registers 71, No. 14; 65, No. 3; 19, No. 5 and 10, No. 7.
2. Amendment of subsection (h)(11) filed 2–5–79; designated effective 4–1–79 (Register 79, No. 6).
3. Order filed 3–8–79 redesignating effective date of previous amendment of subsection (h). New designated effective date is 7–1–79 with respect to new policies effective on or after 7–1–79; new designated effective date is 9–1–79 with respect to renewal policies for periods commencing on or after 9–1–79 (Register 79, No. 10).
4. Amendment of subsection (h)(11) filed 6–25–79 as an emergency; effective upon filing. Certificate of Compliance included (Register 79, No. 26).
5. Amendment of subsection (h)(11) filed 10–18–79; designated effective 1–1–80 (Register 79, No. 42).
6. Repealer filed 4–26–84; effective thirtieth day thereafter (Register 84, No. 17).

§ 2436. Epilepsy; Individual Consideration.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2437. Loss or Loss of Use of Two Legs, Two Arms or Arm and Leg.

HISTORY

1. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2438. Applicant Ineligible Because of Operation by Another May Agree to Limited Coverage.

HISTORY

1. Amendment filed 2–17–65; by amendment filed 3–2–65 designated effective 3–23–65 (Register 65, No. 3).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2439. Eligibility: Finding of Juvenile Court

HISTORY

1. New section filed 2–15–62; designated effective 4–1–62 (Register 62, No. 3).
2. Amendment filed 6–28–63; designated effective 8–1–63 (Register 63, No. 11).
3. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2440. Who May Apply.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2441. Application: Signature and Submission.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2442. Filing Application: Required Contents.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620–11627, Insurance Code.

HISTORY

1. Amendment filed 2–17–65; by amendment filed 3–2–65 designated effective 3–23–65 (Register 65, No. 3). For prior history, see Register 61, No. 1.
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
4. Amendment of subsection (c) filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
5. New subsections (e) and (f) filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
6. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2443. Filing Fee.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624, Insurance Code.

HISTORY

1. Amendment of subsection (b) filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27). For prior history, see Register 81, No. 21.
2. Amendment of subsection (a), repealer of subsection (b) and relettering of subsections (c)–(e) to subsections (b)–(d) filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2443.1. Installment Premium Payment Option.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624, Insurance Code.

HISTORY

1. New section filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
2. Amendment filed 11–7–75; effective thirtieth day thereafter (Register 75, No. 45).
3. Amendment of subsection (a) filed 6–4–76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).
4. Amendment of subsection (a)(7) filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
5. Amendment of subsection (a)(1) filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).
6. Amendment of subsection (a) filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).

7. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2444. Designation of Insurer and Assignment of Risk.

NOTE: Authority cited: Section 11620, Government Code. Reference: Section 11624, Government Code.

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Amendment filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
3. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
4. Amendment of subsection (c) filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).
5. Amendment of subsection (b)(2) filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
6. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2444.5. Original Application and Fee to Be Sent Insurer.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620–11627, Insurance Code.

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 64, No. 21).
2. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
3. Amendment filed 11–7–75; effective thirtieth day thereafter (Register 75, No. 45).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2444.6. Completion of SR 22 Filings by Plan.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622, 11624, Insurance Code.

HISTORY

1. New section filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
2. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2445. Ratio of Insurer's Premiums to Total Premiums.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Amendment filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27).
3. Repealer of subsection (b) filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2445.1. Scope of Operations and Underwriting Policy of Insurer.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622, and 11624, Insurance Code.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
3. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2445.1a. Motor Club Insurers Preferred on Member's Application.

HISTORY

1. Repealer filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2446. Each Vehicle Separately Counted.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections *11621, 11622 and 11624, Insurance Code.*

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Repealer filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).

§ 2446.1. Double Credit for Insurance Required Under Section 2406(b).

HISTORY

1. New section filed 10–10–51; effective thirtieth day thereafter (Register 26, No. 1).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Repealer filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).

§ 2447. Each Renewal Counted.

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Amendment filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2448. Basis for Determining Insurer's Proportion.

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
3. Amendment filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).
4. Amendment filed 6–4–76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).
5. Amendment of subsection (b) filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
6. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2448.1. Reimbursement of Unearned Premium Upon Insolvency of Insurer.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. New section filed 11–7–75; effective thirtieth day thereafter (Register 75, No. 45).
2. Repealer filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).

§ 2449. Insurers Not Subject to Assignment.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2449.1. Notification to Commissioner of Resumption of Bodily Injury and Property Damage Business.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2449.1a. Notification by Commissioner to Manager.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2449.2. Assumption of Obligations by Reinsurers.

NOTE: Authority cited: Section 11620, Insurance Code.

HISTORY

1. New section filed 6–28–63; designated effective 8–1–63 (Register 63, No. 11).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2450. Notice by Insurer of Acceptance or Rejection of Assignment.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620–11627, Insurance Code.

HISTORY

1. Amendment to subsection (a)(4) filed 3–30–72; designated effective 5–1–72 (Register 71, No. 14). For prior history, see Register 71, No. 14.
2. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
3. Amendment filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2450.1. Review by Manager After Rejection; Findings; Notification.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. New section filed 12–17–47; designated to be effective 1–19–48 (Register 14, No. 7).

2. Amendment filed 3-9-50; designated to be effective 4-15-50 (Register 19, No. 5).
3. Amendment filed 6-24-57; designated effective 8-1-57 (Register 57, No. 10).
4. Amendment filed 5-10-60; designated effective 7-1-60, and with respect to all policies both new and renewal, issued pursuant to California Automobile Assigned Risk Plan with effective dates on and after 7-1-60 (Register 60, No. 12).
5. Amendment filed 5-21-81; effective thirtieth day thereafter (Register 81, No. 21).
6. Repealer filed 12-10-86; effective thirtieth day thereafter (Register 86, No. 50).

§ 2450.2. Cancellation by Insurer upon Finding of Ineligibility by Manager.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624(d), Insurance Code.

HISTORY

1. New section filed 5-23-67; designated effective 7-1-67 with respect to all policies with effective dates on and after 7-1-67 (Register 67, No. 21).
2. Amendment filed 7-1-77; designated effective 8-1-77 with respect to all policies, both new and renewal, with effective dates on or after 8-1-77 (Register 77, No. 27).
3. Repealer filed 12-10-86; effective thirtieth day thereafter (Register 86, No. 50).

§ 2450.3. Acceptance Required After Finding of Eligibility.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624(d), Insurance Code.

HISTORY

1. Amendment filed 6-24-57; designated effective 8-1-57 (Register 57, No. 10).
2. Amendment filed 5-23-67; designated effective 7-1-67 with respect to all policies with effective dates on and after 7-1-67 (Register 67, No. 21).
3. Repealer filed 12-10-86; effective thirtieth day thereafter (Register 86, No. 50).

§ 2450.5. Statement of Charges; Method of Payment.

HISTORY

1. Amendment filed 1-3-61; designated effective 3-1-61, and with respect to all policies, both new and renewal, issued pursuant to the California Automobile Assigned Risk Plan, with effective dates on and after 3-1-61 (Register 61, No. 1).
2. Amendment filed 3-30-71; designated effective 6-1-71 (Register 71, No. 14).
3. Repealer filed 8-25-2004; operative 9-24-2004 (Register 2004, No. 35).

§ 2451. Issuance of Policy; Filing of Certificates.

HISTORY

1. Repealer filed 5-23-67; designated effective 7-1-67 (Register 67, No. 21).

§ 2452. Notice to Manager of Issuance of Policy.

HISTORY

1. Repealer filed 5-23-67; designated effective 7-1-67 (Register 67, No. 21).

§ 2453. Notice of Failure to Pay Premium.

HISTORY

1. Amendment filed -10-60; designated effective 7-1-60, and with respect to all policies both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after 7-1-60 (Register 60, No. 12).
2. Amendment filed 6-28-63; designated effective 8-1-63 (Register 63, No. 11).
3. Amendment filed 5-23-67; designated effective 7-1-67 with respect to all policies with effective dates on and after 7-1-67 (Register 67, No. 21).
4. Amendment filed 3-30-72; designated effective 5-1-72 (Register 72, No. 14).
5. Repealer filed 8-25-2004; operative 9-24-2004 (Register 2004, No. 35).

§ 2454. Agreements Between Insurers Re Performance of Obligation.

HISTORY

1. New section filed 2-15-62; designated effective (Register 62, No. 3).
2. Repealer filed 8-25-2004; operative 9-24-2004 (Register 2004, No. 35).

§ 2460. Rates for Assigned Risks.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620-11627, Insurance Code.

HISTORY

1. Amendment of subsection (a) filed 7-1-77; designated effective 8-1-77 with respect to all policies, both new and renewal, with effective dates on or after 8-1-77 (Register 77, No. 27). For prior history, see Register 76, No. 23.
2. Repealer and new section filed 11-7-78; designated effective 1-1-79 with respect to new policies effective on or after 1-1-79 and designated effective 2-1-79 with respect to renewal policies for periods commencing on or after 2-1-79 (Register 78, No. 45).
3. Amendment filed 2-5-79; designated effective 4-1-79 (Register 78, No. 45).
4. Order filed 3-8-79 redesignating effective date of previous amendment (filed 2-5-79). New designated effective date is 7-1-79 with respect to new policies effective on or after 7-1-79; new designated effective date is 9-1-79 with respect to renewal policies for periods commencing on or after 9-1-79 (Register 79, No. 10).
5. Amendment filed 6-25-79 as an emergency; effective upon filing. Certificate of Compliance included (Register 79, No. 26).
6. Amendment filed 10-18-79; designated effective 1-1-80 (Register 79, No. 42).
7. Repealer filed 8-25-2004; operative 9-24-2004 (Register 2004, No. 35).

§ 2460.1. Maximum Basic Surcharge.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620-11627, Insurance Code.

HISTORY

1. Amendment filed 6-4-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23). For prior history, see Register 72, No. 14.
2. Repealer filed 2-5-79; designated effective 4-1-79 (Register 79, No. 6).
3. Order filed 3-8-79 redesignating effective date of previous repealer (filed 2-5-79). New designated effective date is 7-1-79 with respect to new policies effective on or after 7-1-79; new designated effective date is 9-1-79 with respect to renewal policies for periods commencing on or after 9-1-79 (Register 79, No. 10).
4. New section filed 6-25-79 as an emergency; effective upon filing. Certificate of Compliance included (Register 79, No. 26).
5. Repealer filed 10-18-79; designated effective 1-1-80 (Register 79, No. 42).

§ 2460.2. Uninsured Motorist Coverage Rates.

HISTORY

1. Amendment filed 2-17-65; by amendment filed 3-2-65 designated effective 3-23-65 (Register 65, No. 3). For prior history, see Register 61, No. 1.
2. Repealer and new section filed 5-23-67; designated effective 7-1-76 with respect to all policies with effective dates on and after 7-1-67 (Register 67, No. 21).
3. Amendment filed 11-7-75; effective thirtieth day thereafter (Register 75, No. 45).
4. Repealer filed 10-18-79; designated effective 1-1-80 (Register 79, No. 42).

§ 2460.3. Merit/Demerit Rating Plan.

NOTE: Authority cited: Section 11620, Government Code. Reference: Section 11624, Government Code.

HISTORY

1. Repealer and new section filed 11-7-78; designated effective 1-1-79 with respect to new policies effective on or after 1-1-79 and designated effective 2-1-79 with respect to renewal policies for periods commencing on or after 2-1-79 (Register 78, No. 45). For history of former Section 2460.3, see Registers 75, No. 45; 72, No. 14; 71, No. 14; 65, No. 3; 61, No. 1.
2. Amendment of subsections (b), (d), (e) and (g) filed 6-29-82; designated effective 8-1-82 (Register 82, No. 27).
3. Amendment of subsection (g) filed 12-10-86; effective thirtieth day thereafter (Register 86, No. 50).
4. Repealer filed 8-25-2004; operative 9-24-2004 (Register 2004, No. 35).

§ 2460.4. Additional Surcharge, Accidents, Specific Offenses.

NOTE: Authority cited: Section 11620, Government Code. Reference: Sections 11620-11627, Government Code.

HISTORY

1. Amendment filed 2-17-65; by amendment filed 3-2-65 designated effective as to new policies on 3-23-65, and as to renewal policies on 5-10-65. Certificate of Compliance included (Register 65, No. 3). For prior history see Register 61, No. 1.
2. Amendment filed 5-23-67; designated effective 7-1-67 with respect to all policies with effective dates on and after 7-1-67 (Register 67, No. 21).
3. Amendment filed 3-30-71; designated effective 6-1-71 (Register 71, No. 14).
4. New subsection (c) filed 11-7-75; effective thirtieth day thereafter (Register 75, No. 45).
5. Repealer filed 11-7-78; designated effective 1-1-79 with respect to new policies effective on or after 1-1-79 and designated effective 2-1-79 with respect to renewal policies for periods commencing on or after 2-1-79 (Register 78, No. 45).

§ 2460.5. All Other Certificated Risks.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. New section filed 11–7–75; effective thirtieth day thereafter (Register 75, No. 45).
2. Amendment of subsection (a) filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
3. Amendment of subsections (a) and (c)(1) filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2461. Increased Charge for Greater Hazard Subject to Committee Approval.

HISTORY

1. Amendment filed 5–10–60; designated effective 7–1–60, and with respect to all policies both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after 7–1–60 (Register 60, No. 12).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2462. Rates Fixed: Special Arrangements Subject to Committee Approval.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 1162 and 11624, Insurance Code.

HISTORY

1. Amendment filed 5–10–60; designated effective 7–1–60, and with respect to all policies both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after 7–1–60 (Register 60, No. 12).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Amendment filed 6–4–76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 23).
4. Amendment filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
5. Amendment of subsection (a)(1) filed 10–18–79; designated effective 1–1–80 (Register 79, No. 42).
6. Amendment of subsection (b) filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
7. Amendment filed 8–19–82; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 82, No. 34).
8. Amendment of subsection (a)(2) filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
9. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2463. Limited Payment to Licensed Agent.

HISTORY

1. Repealer filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).

§ 2470. Grounds; Statement of Grounds and Approval of Manager Required.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2471. Cancellation for Default in Payment.

HISTORY

1. Amendment filed 5–10–60; designated effective 7–1–60, and with respect to all policies both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after 7–1–60 (Register 60, No. 12).
2. Amendment filed 11–7–75; effective thirtieth day thereafter (Register 75, No. 45).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2471.1. Cancellation for Reasons Other Than Non–Payment of Premium.

NOTE: Authority cited: Section 11620, California Insurance Code. Reference: Sections 11620–11627, California Insurance Code.

HISTORY

1. New section filed 11–7–75; effective thirtieth day thereafter (Register 75, No. 45).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2472. Copy of Notice to Producer.

HISTORY

1. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2480. Assignment to Another Insurer.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2481. Voluntary Insurance at Normal Rates.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2482. Renewal and Refusal to Renew; Risk Under Plan Not More Than 24 Months.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620–11627, Insurance Code.

HISTORY

1. Amendment filed 6–28–63; designated effective 8–1–63 (Register 63, No. 11). For prior history see Register 62, No. 3.
2. Amendment filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
3. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
4. Amendment filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
5. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2482.1. Notice of Intention; Statement of Grounds of Refusal.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Amendment filed 5–10–60; designated effective 7–1–60, and with respect to all policies both new and renewal, issued pursuant to California Automobile Assigned Risk Plan, with effective dates on and after 7–1–60 (Register 60, No. 12).
3. Amendment filed 2–15–62; designated effective 4–1–62 (Register 62, No. 3).
4. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
5. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
6. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2482.3. Review of Notice of Refusal; Finding.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2482.5. Obligation to Renew.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2483. to 2483.2, inclusive.

HISTORY

1. New §§ 2483 to 2483.2, inclusive, filed 12–17–47 designated to be effective 1–19–48 (Register 10, No. 7).
2. Repealer of §§ 2483 to 2483.2, inclusive, filed 3–9–50 designated to be effective 4–15–50 (Register 19, No. 5).

§ 2483.3. Three Consecutive Years Limit for Assignments.

HISTORY

1. New section filed 3–9–50 designated to be effective 4–15–50 (Register 19, No. 5).
2. Amendment filed 1–25–52; effective thirtieth day thereafter (Register 27, No. 2).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2483.4. Alternative Courses upon Expiration of Policy.

HISTORY

1. New section filed 1–25–52; effective thirtieth day thereafter (Register 27, No. 2).
2. Amendment filed 6–24–57; designated effective 8–1–57 (register 57, No.10).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2483.5. Notice of Intended Procedure; Time.

HISTORY

1. New section filed 1–25–52; effective thirtieth day thereafter (Register 27, No. 2).
2. Amendment filed 6–28–63; designated effective 8–1–63 (Register 63, No. 11).
3. Amendment filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2483.6. Reapplication.

HISTORY

1. New section filed 1–25–52; effective thirtieth day thereafter (Register 27, No. 2).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2484. and 2485.

HISTORY

1. New sections filed 12–17–47 designated to be effective 1–19–48 (Register 10, No. 7).
2. Repealer filed 3–9–50 designated to be effective 4–15–50 (Register 19, No. 5).

§ 2490. Assessments; Fee.

HISTORY

1. Amendment filed 2–17–65; by amendment filed 3–2–65 designated effective 3–23–65. Certificate of Compliance included (Register 65, No. 3).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2491. Prompt Payment Required.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2492. Records Required.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2492.1. Annual Report of Assignments, Etc.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. New section filed 12–17–47 designated to be effective 1–19–48 (Register 10, No. 7).
2. Amendment filed 3–9–50 designated to be effective 4–15–50 (Register 19, No. 5).
3. Amendment filed 5–23–67; designated effective 7–11–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
4. Amendment filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).
5. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
6. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2492.3. Annual Report of Premiums and Losses.

HISTORY

1. Amendment filed 5–23–67; designated 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21). For prior history, see Register 62, No. 3.
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2492.5. Manager: Reports and Records.

HISTORY

1. Editorial correction removing extraneous text to section 2493 (Register 99, No. 7).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2493. Insurers: Records and Reports.

HISTORY

1. Editorial correction restoring section 2493 (Register 99, No. 7).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2493.2. Reports to Governing Committee.

HISTORY

1. New section filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2493.4. Reports to Designated Statistical Agency.

HISTORY

1. New section filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2494. Committee Record of Funds.

HISTORY

1. Amendment filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Amendment filed 3–30–72; designated effective 5–1–72 (Register 72, No. 14).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2494.5. Commissioner May Require Other Reports and Records.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2494.6. Rejections; Notice to Department of Motor Vehicles.

HISTORY

1. New section filed 6–24–57; designated effective 8–1–57 (Register 57, No. 10).
2. Repealer filed 3–3–71; designated effective 6–1–71 (Register 71, No. 14).

§ 2494.7. Indemnity.

NOTE: Authority cited: Section 11620, Insurance Code.

HISTORY

1. New section filed 3–30–71; designated effective 6–1–71 (Register 71, No. 14).
2. Amendment filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2495. Parties and Procedure; Disqualified Members to Be Replaced; Committee's Decision Appealable to Commissioner.

HISTORY

1. New section filed 12–17–47 designated to be effective 1–19–48 (Register 10, No. 7).
2. Amendment filed 3–9–50 designated to be effective 4–15–50 (Register 19, No. 5).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2496. Commissioner May Examine Business of Plan; Cost to Be Charged to Plan.

HISTORY

1. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2497. Printed Copies of Forms to Be Available.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11620–11627, Insurance Code.

HISTORY

1. Amendment filed 10–4–74; designated effective 12–1–74 (Register 74, No. 40).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498. Every Liability Insurer Required to Subscribe; Form of Subscription.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Sections 11621, 11622 and 11624, Insurance Code.

HISTORY

1. Amendment filed 7–29–53; designated effective 9–1–53 (Register 53, No. 13).
2. Amendment filed 5–23–67; designated effective 7–1–67 with respect to all policies with effective dates on and after 7–1–67 (Register 67, No. 21).
3. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.1. Supplement of Rules for Private Passenger Automobiles.

NOTE: Authority cited: Section 11620, Government Code. Reference: Sections 11621, 11622 and 11624, Government Code.

HISTORY

1. New section filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27). Note: Formerly "California Automobile Assigned Risk Plan Rate Supplement," part of Section 2498. For prior history, see Register 74, No. 40.
2. Amendment of subsection (b)(4) filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).
3. Amendment of subsection (b)(2) filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
4. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.2. California Territories.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624, Insurance Code.

HISTORY

1. Repealer and new section filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45). For prior history, see Registers 77, No. 27; 74, No. 40.
2. Amendment filed 12–29–78; effective thirtieth day thereafter (Register 79, No. 2).
3. Editorial correction of subsection designations (Register 79, No. 2).
4. Amendment of subsection (a) and (b) filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
5. Amendment filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).
6. Amendment filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
7. Change without regulatory effect redesignating subsections (a)–(c) as paragraphs 1.–3., amending newly designated paragraphs 1.–2. and amending *California Automobile Association Assigned Risk Plan Manual* (incorporated by reference) filed 7–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 27).
8. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.3. Liability Rates for Private Passenger Automobile Risks Other Than Fleets.

NOTE: Authority cited: Section 11624(d), Insurance Code. Reference: Sections 11622 and 11624, Insurance Code.

HISTORY

1. Repealer and new section filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45). For prior history, see Registers 77, Nos. 40 and 27.
2. Amendment filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
3. Amendment filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).
4. Amendment filed 4–26–84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 17).
5. Amendment filed 1–31–85; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 85, No. 5).
6. Amendment filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
7. Amendment filed 12–16–87; operative 12–15–87 with respect to new policies; and operative 1–15–88 with respect to renewal policies (Register 87, No. 52).
8. Repealer filed 3–11–99 pursuant to Government Code section 11343.8; operative 7–1–99 (Register 99, No. 11).

§ 2498.3.1. Mature Driver Improvement Course Discount.

NOTE: Authority cited: Section 11624(d), Insurance Code. Reference: Sections 11622 and 11624, Insurance Code.

HISTORY

1. New section not filed with Secretary of State; operative 9–1–87. Submitted to OAL for printing only pursuant to Government Code Section 11343.8 (Register 87, No. 42).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.4. Automobile Liability Insurance Rules and Rates for Named Non–Owner Policies.

HISTORY

1. New section filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27).
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.4.1. Extended Non–Owned Coverage for Named Individual or Use of Other Automobiles—Broad Form Coverage.

NOTE: Authority cited: Section 11620, Insurance Code. Reference: Section 11624(e), Insurance Code.

HISTORY

1. New section filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27).
2. Amendment filed 12–10–86; effective thirtieth day thereafter (Register 86, No. 50).
3. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.4.2. "Emergency" Use of Other Automobiles.

HISTORY

1. New section filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27). For prior history see Register 76, No. 31.
2. Repealer filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).

§ 2498.4.3. Protection Against Uninsured Motorists Insurance Per Section 2408

NOTE: Authority cited: Section 11620, Government Code. Reference Sections 11620–11627, Government Code.

HISTORY

1. New section filed 7–1–77; designated effective 8–1–77 with respect to all policies, both new and renewal, with effective dates on or after 8–1–77 (Register 77, No. 27).
2. Correction of amendment to "California Assigned Risks Rate Supplement—Protection Against Uninsured Motorists Insurance Per Section 2408," previously filed 7–29–76, designated effective 10–1–76, filed 9–30–77 (Register 77, No.40).
3. Repealer filed 11–7–78; designated effective 1–1–79 with respect to new policies effective on or after 1–1–79 and designated effective 2–1–79 with respect to renewal policies for periods commencing on or after 2–1–79 (Register 78, No. 45).

§ 2498.4.9. California Automobile Assigned Risk Plan Plan of Operations.

The Insurance Commissioner has approved a separate plan designated the "California Automobile Assigned Risk Plan Plan of Operations" under this section. This plan has been filed but for the present is separately published, not as part of the California Code of Regulations. The plan referred to in Section 2498.4.9 may be examined at the office of the Insurance Commissioner in San Francisco, and copies may be obtained from the California Automobile Assigned Risk Plan, P.O. Box 7917, San Francisco, California 94120–7917. The most current plan is effective as of September 24, 2004 with subsequent amendments with effective dates through July 24, 2008.

NOTE: Authority cited: Sections 11620 and 11624, Insurance Code. Reference: Sections 11580.9 and 11620–11627, Insurance Code.

HISTORY

1. New section and adoption of new "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 8–25–2004; operative 9–24–2004 (Register 2004, No. 35).
2. Amendment of section and amendment of "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 8–26–2004; operative 9–25–2004 (Register 2004, No. 35).
3. Amendment of section and amendment of "California Automobile Assigned Risk Plan Plan of Operations" filed 10–26–2004; operative 11–25–2004 (Register 2004, No. 44).
4. Change without regulatory effect amending the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 12–21–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 52).
5. Change without regulatory effect amending the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 12–22–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 52).

6. Change without regulatory effect amending the "California Automobile Assigned Risk Plan Plan of Operations — Portfolio of Endorsements and Forms" (incorporated by reference) filed 9–28–2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 39).
7. Amendment of section and amendment of "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) provisions "How to Apply to the Plan," "Electronic Format," and sections 1, 20, 41, and 46 filed 4–18–2006; operative 5–18–2006 (Register 2006, No. 16).
8. Amendment of section and amendment of "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) sections 14, 16, 20, 23, 37, 40, 41, 43, 47 and 54 filed 4–18–2006; operative 5–18–2006 (Register 2006, No. 16).
9. Amendment of section and amendment of "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) section 8 filed 7–12–2006; operative 8–11–2006 (Register 2006, No. 28).
10. Amendment of section and amendment of "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 10–10–2006; operative 11–9–2006 (Register 2006, No. 41).
11. Amendment of section and amendment of sections 1, 26, 37, 44 and 54 of the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 6–28–2007; operative 7–28–2007 (Register 2007, No. 26).
12. Amendment of section and amendment of section 8 of the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 6–28–2007; operative 7–28–2007 (Register 2007, No. 26).
13. Amendment of section and amendment of the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 6–28–2007; operative 7–28–2007 (Register 2007, No. 26).
14. Amendment of section and amendment of the introduction and sections 8, 28, 33, 37, 43 and 48 of the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 6–28–2007; operative 7–28–2007 (Register 2007, No. 26).
15. Change without regulatory effect amending section and sections 20, 26 and 44 of the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 7–23–2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 30).
16. Change without regulatory effect amending section and sections 28 and 46 of the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) filed 7–23–2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 30).
17. Change without regulatory effect amending section and Commercial Auto Endorsement forms within the "California Automobile Assigned Risk Plan Plan of Operations" (incorporated by reference) and amending NOTE filed 7–24–2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 30).

§ 2498.5. California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates.

The Insurance Commissioner has approved a separate manual designated the "California Automobile Assigned Risk Plan Simplified Manual of Rules And Rates" under this Section. This manual has been filed but for the present is separately published, not as part of the California Code of Regulations. The manual referred to in Section 2498.5 may be examined at the office of the Insurance Commissioner in San Francisco, and copies may be obtained from the California Automobile Assigned Risk Plan, P.O. Box 7917, San Francisco, California 94120–7917. The most current manual is effective as of July 1, 1999 with subsequent amendments with effective dates through July 28, 2007.

NOTE: Authority cited: Sections 11620 and 11624(d), Insurance Code. Reference: Sections 11622 and 11624, Insurance Code.

HISTORY

1. A new section filed 6–25–79 as an emergency; effective upon filing. Certificate of Compliance included (Register 79, No. 26). For prior history, see Register 79, No. 10; 79, No. 6; 78, No. 45; 77, No. 27; and 76, No. 23.
2. Amendment of Rule 2 filed 9–27–79 as an emergency; designated effective 10–1–79. Certificate of Compliance included (Register 79, No. 39).
3. Amendment filed 10–18–79; designated effective 1–1–80 (Register 79, No. 42).
4. Amendment of Rule 6 filed 5–21–81; effective thirtieth day thereafter (Register 81, No. 21).
5. Amendment of Rule 5 filed 11–18–81 as an emergency; designated effective 1–1–82 (Register 81, No. 48).
6. *Order of Repeal of 11–18–81 emergency order filed 11–27–81 by OAL pursuant to Government Code Section 11349.6 (Register 81, No. 48).*
7. Amendment of Rule 5 filed 6–29–82; designated effective 8–1–82 (Register 82, No. 27).
8. Amendment filed 4–26–84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 17).
9. Amendment of Rule 46 of the "California Automobile Assigned Risk Plan" (incorporated by reference) filed with the Secretary of State 4–8–98 pursuant to Government Code section 11343.8; operative 5–1–98. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11343(a)(1)) (Register 98, No. 15).
10. Amendment of section heading and section and amended "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" filed with the Secretary of State 3–11–99 pursuant to Government Code section 11343.8; operative 7–1–99. Amended manual filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11343(a)(1)) (Register 99, No. 11).
11. Amendment of section and Rule 94 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" filed with the Secretary of State 8–26–2004 pursuant to Government Code section 11343.8; operative 9–25–2004. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2004, No. 35).
12. Amendment of section and Rule 75 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" filed with the Secretary of State 8–26–2004 pursuant to Government Code section 11343.8; operative 9–25–2004. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2004, No. 35).
13. Amendment of section and amended "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" filed with the Secretary of State 10–26–2004 pursuant to Government Code section 11343.8; operative 11–25–2004. Amended manual filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Register 2004, No. 44).
14. Change without regulatory effect amending Rules 24 and 55 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 12–21–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 52).
15. Change without regulatory effect amending Rule 123 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 12–21–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 52).
16. Change without regulatory effect amending Rule 54 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 12–22–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 52).
17. Change without regulatory effect amending Rule 53 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 12–22–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 52).
18. Amendment of section and Rule 122 of the *California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates* filed with the Secretary of State 12–28–2005 pursuant to Government Code section 11343.8; operative 1–27–2006. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2005, No. 52).
19. Amendment of section and Rules 21, 26, 57, 94, 133 and 141 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed with the Secretary of State 4–20–2006 pursuant to Government Code section 11343.8; operative 5–20–2006. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2006, No. 16).
20. Change without regulatory effect amending the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) and amending section filed 7–18–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 29).
21. Amendment of section and Rule 50 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed with the Secretary of State 10–3–2006 pursuant to Government Code section 11343.8; operative 11–2–2006. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2006, No. 40).
22. Amendment of section and "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 11–9–2006 pursuant to Government Code section 11343.8; operative 11–9–2006. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2006, No. 45).
23. Amendment of section and Rules 5, 122 and 124 of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2007, No. 26).
24. Amendment of section and Rules 24, 55, 140 and Private Passenger Rate Pages of the "California Automobile Assigned Risk Plan Simplified Manual of Rules and Rates" (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2007, No. 26).

§ 2498.6. California Automobile Insurance Low Cost Program Plan of Operations.

The Insurance Commissioner has approved and hereby incorporates by reference a separate plan designated the "California Automobile Insurance Low Cost Program Plan of Operations," effective June 19, 2001, with nonsubstantive amendments effective February 27, 2002, and with nonsubstantive amendments effective June 20, 2002, and with emergency amendments effective January 13, 2003, and with amendments effective February 15, 2003, and with emergency regulations readopted effective May 6, 2003, and with nonsubstantive amendments effective August 28, 2003, and with amendments effective September 9, 2003, and with amendments effective October 2, 2003, and with nonsubstantive amendments effective April 19, 2004, and with nonsubstantive amendments effective August 24, 2004, and with amendments effective August 28, 2004, and with amendments effective February 13, 2005, with nonsubstantive amendments effective July 23, 2005, and with amendments effective January 20, 2006, and with emergency amendments effective April 1, 2006, and with emergency amendments effective June 1, 2006, and with nonsubstantive amendments effective July 18, 2006, and with emergency amendments readopted July 24, 2006, and with emergency amendments readopted effective October 2, 2006, and with amendments effective December 27, 2006, and with emergency amendments effective March 30, 2007, and with nonsubstantive amendments effective April 24, 2007, and with amendments effective July 28, 2007, and with emergency amendments effective October 1, 2007, and with amendments effective October 10, 2007, and with nonsubstantive amendments effective November 2, 2007, and with emergency amendments effective December 10, 2007, and with emergency amendments readopted effective March 31, 2008, and with amendments effective July 17, 2008, and with nonsubstantive amendments effective July 30, 2008, which is the statutorily–required plan for the equitable apportionment, among insurers required to participate in the California Automobile Assigned Risk Plan, of persons residing in the County of Los Angeles, the City and County of San Francisco, and the Counties of Alameda, Fresno, Orange, Riverside, San Bernardino, San Diego, Contra Costa, Imperial, Kern, Sacramento, San Joaquin, San Mateo, Santa Clara, Stanislaus, Merced, Monterey, Santa Barbara, Sonoma, Tulare, Ventura, Santa Cruz, Solano, Marin, Madera, Placer, Napa, Yolo, Mendocino, Kings, Lake, Amador, Butte, El Dorado, Calaveras, Humboldt, San Benito, Shasta, Sutter, Tuolumne, Yuba, Alpine, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Nevada, Plumas, San Luis Obispo, Sierra, Siskiyou, Tehama and Trinity who are eligible to purchase a low cost automobile insurance policy through the program established in those counties. The Plan also sets forth procedures which insurance producers and applicants shall follow to obtain a low cost automobile insurance policy. A low cost automobile insurance policy is available for policies issued or renewed on and after July 1, 2000. This Plan has been filed but for the present is separately published, not as part of the California Code of Regulations. The Plan may be examined at the office of the Insurance Commissioner in San Francisco and copies may be obtained from the California Automobile Assigned Risk Plan, P.O. Box 7917, San Francisco, California 94120–7917.

NOTE: Authority cited: Sections 11620, 11629.7, 11629.72, 11629.73 and 11629.79, Insurance Code. Reference Sections 11629.7–11629.85, Insurance Code.

HISTORY

1. New section and new *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 3–27–2000 as an emergency; operative 3–27–2000 (Register 2000, No. 13). A Certificate of Compliance must be transmitted to OAL by 7–25–2000 or emergency language will be repealed by operation of law on the following day.
2. New section and new *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) refiled 7–25–2000 as an emergency; operative 7–25–2000 (Register 2000, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–22–2000 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 7–25–2000 order transmitted to OAL 11–21–2000; disapproved 1–8–2001 (Register 2001, No. 2).
4. New section and new *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 1–8–2001 as an emergency; operative 1–8–2001 (Register 2001, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–8–2001 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 1–8–2001 order, including addition of effective date of incorporated manual, transmitted to OAL 5–7–2001 and filed 6–19–2001 (Register 2001, No. 25).
6. Change without regulatory effect amending section and NOTE and amending *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 2–27–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 9).
7. Change without regulatory effect amending section and amending *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 6–20–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 25).
8. Amendment of section and amendment of *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 1–13–2003 as an emergency; operative 1–13–2003 (Register 2003, No. 3). A Certificate of Compliance must be transmitted to OAL by 5–13–2003 or emergency language will be repealed by operation of law on the following day.
9. Amendment of section and amendment of *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 1–16–2003; operative 2–15–2003 (Register 2003, No. 3).
10. Amendment of section, including indication of readoption of amendment of *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) refiled 5–6–2003 as an emergency; operative 5–6–2003 (Register 2003, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–3–2003 or emergency language will be repealed by operation of law on the following day.
11. Change without regulatory effect amending section and amending *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 8–28–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 35).
12. Amendment of section and amendment of *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 9–2–2003; operative 10–2–2003 (Register 2003, No. 36).
13. Certificate of Compliance as to 5–6–2003 order, including further amendment of date, transmitted to OAL 7–31–2003 and filed 9–9–2003 (Register 2003, No. 37).
14. Change without regulatory effect amending section and NOTE and amending *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 4–19–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 17).
15. Amendment of section and NOTE and amendment of *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 7–29–2004; operative 8–28–2004 (Register 2004, No. 31).
16. Change without regulatory effect amending section and amending *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 8–24–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 35).
17. Amendment of section and amendment of *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) filed 1–14–2005; operative 2–13–2005 (Register 2005, No. 2).
18. Change without regulatory effect amending the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 6–23–2005; operative 7–23–2005 (Register 2005, No. 25).
19. Editorial correction of HISTORY 18 (Register 2006, No. 3).
20. Amendment of section 27 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) and amendment of section and NOTE filed with the Secretary of State 1–26–2006 pursuant to Government Code section 11343.8; operative 1–26–2006. Amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2006, No. 3).
21. Repealer of section 27 and adoption of new section 27 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) and amendment of section filed with the Secretary of State as an emergency on 3–24–2006 pursuant to Government Code section 11343.8; operative 4–1–2006. New section 27 and amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2006, No. 12).
22. Relettering and amendment of former Exhibit K to Exhibit E in section 27 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) and amendment of section filed 5–18–2006 as an emergency; operative 6–1–2006. The establishment of rates for each county in section 27 was filed without review by OAL pursuant to Government Code section 11340.9(g). A Certificate of Compliance must be transmitted to OAL by 9–29–2006 or emergency language will be repealed by operation of law on the following day (Register 2006, No. 20).
23. Change without regulatory effect amending the "California Automobile Insurance Low Cost Program Plan of Operations" (incorporated by reference) and amending section filed 7–18–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 29).

24. Repealer of section 27 and adoption of new section 27 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) and amendment of section refiled with the Secretary of State as an emergency on 7–24–2006 pursuant to Government Code section 11343.8; operative 7–24–2006. Section 27 and amendment filed without review by OAL pursuant to exemption for regulations that establish or fix rates (Government Code section 11340.9(g)) (Register 2006, No. 30).

25. Relettering and amendment of former Exhibit K to Exhibit E in section 27 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) and amendment of section adding eight counties refiled 10–2–2006 as an emergency; operative 10–2–2006. The establishment of rates for each new county in section 27 was filed without review by OAL pursuant to Government Code section 11340.9(g). A Certificate of Compliance must be transmitted to OAL by 1–30–2007 or emergency language will be repealed by operation of law on the following day (Register 2006, No. 40).

26. Certificate of Compliance as to 7–24–2006 and 10–2–2006 orders, including amendment of rates, transmitted to OAL 11–14–2006 and filed 12–27–2006; amendment of rates exempt from the APA and OAL review pursuant to Government Code section 11340.9(g) (Register 2006, No. 52).

27. Amendment of section and Exhibit E of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference), adding six counties and insurance rates for those counties, filed 3–9–2007 as an emergency pursuant to Insurance Code section 11629.79; operative 3–30–2007. The establishment of rates for each new county was filed without review by OAL pursuant to Government Code section 11340.9(g). A Certificate of Compliance must be transmitted to OAL by 9–26–2007 or emergency language will be repealed by operation of law on the following day (Register 2007, No. 10).

28. Change without regulatory effect amending the *California Automobile Insurance Low Cost Program Plan of Operations* (incorporated by reference) and amending section and NOTE filed 4–24–2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 17).

29. Amendment of section and amendment of section 8 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007 (Register 2007, No. 26).

30. Amendment of section and amendment of sections 8, 14 and 15 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007 (Register 2007, No. 26).

31. Amendment of section and amendment of section 8, subsection B.8.a. of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007 (Register 2007, No. 26).

32. Amendment of section and amendment of sections 4, 14, 19, 20, 26, 28, 33, 34 and 37 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007 (Register 2007, No. 26).

33. Amendment of section and amendment of sections 1, 26 and 37 of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 6–28–2007 pursuant to Government Code section 11343.8; operative 7–28–2007 (Register 2007, No. 26).

34. Amendment of section and Exhibit E of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference), adding twenty counties and insurance rates for those counties, filed 9–17–2007 as an emergency pursuant to Insurance Code section 11629.79; operative 10–1–2007 (Register 2007, No. 38). The establishment of rates for each new county was filed without review by OAL pursuant to Government Code section 11340.9(g). A Certificate of Compliance must be transmitted to OAL by 3–31–2008 or emergency language will be repealed by operation of law on the following day.

35. Reinstatement of section as it existed prior to 3–9–2007 emergency amendment pursuant to Government Code section 11346.1(f) (Register 2007, No. 41).

36. Amendment of section and Exhibit E of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference), adding six counties and insurance rates for those counties, filed 10–10–2007; operative 10–10–2007 pursuant to Government Code section 11343.4. The establishment of rates for each new county was filed without review by OAL pursuant to Government Code section 11340.9(g) (Register 2007, No. 41).

37. Change without regulatory effect amending the "California Automobile Insurance Low Cost Program Plan of Operations" (incorporated by reference) and amending section filed 11–2–2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 44).

38. Amendment of section and Exhibit E of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference), adding sixteen counties and insurance rates for those counties, filed 11–15–2007 as an emergency pursuant to Insurance Code section 11629.79; operative 12–10–2007. The establishment of rates for each new county was filed without review by OAL pursuant to Government Code section 11340.9(g) (Register 2007, No. 46). A Certificate of Compliance must be transmitted to OAL by 6–9–2008 or emergency language will be repealed by operation of law on the following day.

39. Amendment of section and Exhibit E of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference), adding twenty counties and insurance rates for those counties, refiled 3–18–2008 as an emergency pursuant to Insurance Code section 11629.79; operative 3–31–2008. The establishment of rates for each new county was filed without review by OAL pursuant to Government Code section 11340.9(g) (Register 2008, No. 12). A Certificate of Compliance must be transmitted to OAL by 6–30–2008 or emergency language will be repealed by operation of law on the following day.

40. Certificate of Compliance as to 11–15–2007 and 3–18–2008 orders, including further amendment of section, transmitted to OAL 6–5–2008 and filed 7–17–2008; the establishment of rates for each county is exempt from the APA and OAL review pursuant to Government Code section 11340.9(g) (Register 2008, No. 29).

41. Change without regulatory effect amending section and amending Exhibit C "Income Eligibility Guidelines" of the *California Low Cost Automobile Insurance Program Plan of Operations* (incorporated by reference) filed 7–30–2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 31).

Article 8.5. Cancellation Notices—Automobile Liability Insurance Policies

§ 2499. Contents of Statement.

The statement required to be contained in every notice of cancellation of an automobile liability policy pursuant to Insurance Code Section 652 shall read as follows:

"Pursuant to Section 652 of the Insurance Code you are hereby notified that:

"1. The California Automobile Assigned Risk Plan provides a means by which applicants for automobile bodily injury and property damage liability insurance may be assigned to an insurer authorized to transact liability insurance.

"2. If you are unable to procure such insurance through ordinary methods and you are in good faith eligible for such insurance in accordance with the standards of the Plan, it is possible for you to obtain it through the Plan.

"3. Application forms for insurance through the Plan may be obtained from and submitted through (a) any licensed insurance agent or broker or (b) the Plan itself at 425 California Street, P.O. Box 7917, San Francisco, CA 94120."

Each insurer is authorized and directed to alter the above statement by inserting on its next reprint thereof any changed address of the California Automobile Assigned Risk Plan of which it may be notified by the Commissioner or by the Plan itself.

NOTE: Authority cited: Section 652 and 665, Insurance Code. Reference: Sections 660–669.5, Insurance Code.

HISTORY

1. New Article 8.5 (Sections 2499 and 2499.5) filed 9–15–61 as an emergency; effective upon filing (Register 61, No. 18).
2. Certificate of Compliance filed and refiling of Sections 2499 and 2499.5 on 11–30–61 (Register 61, No. 24).
3. Amendment filed 11–29–79 as procedural and organizational; effective upon filing (Register 79, No. 48).

§ 2499.5. Form of Statement.

Such statement shall be legible. The size of the type thereof shall be not less than that used in the notice of cancellation. It may be embodied in the notice of cancellation itself, printed or typed on the face or reverse side thereof, rubber stamped thereon, affixed thereto by a sticker or placed thereon in any other manner which will make it a part of said notice and render its detachment or removal thereof clearly discernible.

§ 2499.7. Statement: Optional Sentence.

Any insurer may at its option substitute for the first sentence of the statement prescribed by Section 2499 the following:

"Section 652 of the Insurance Code requires that you be notified concerning the California Automobile Assigned Risk Plan in the manner set forth in the three numbered paragraphs below. This notice does not necessarily mean that you must seek insurance through the Assigned Risk Plan or that you are necessarily eligible to secure it through the Plan."

HISTORY

1. New section filed 11-30-61; effective thirtieth day thereafter (Register 61, No. 24).

Article 9. Workers' Compensation Insurance. Dividends (Refunds) to Policyholders. Regulations Governing Classification of Risks and Premium Rates, Policy and Endorsement Forms.

§ 2500. Application and Effective Date of Article.

This article applies to all stock, mutual and reciprocal inter-insurance exchange insurers and to the State Compensation Insurance Fund. The provisions of this article are effective April 1, 1976, except as otherwise provided in Sections 2507.2 and 2508 hereof.

NOTE: Authority cited: Sections 790-790.10, 11630-11663 and 11730-11742, Insurance Code. Reference: Sections 380, 381, 383, 750-766, 780—784, 790-790.10, 1420, 11630-11663 and 11730-11742, Insurance Code.

HISTORY

1. New Article 9 (Sections 2500 through 2507) filed 3-3-58; effective thirtieth day thereafter (Register 58, No. 4).
2. Repealer of Article 9 (Sections 2500-2507) and New Article 9 (Sections 2500-2507, 2507.1-2507.2, 2508-2509) filed 2-6-76; designated effective 4-1-76 (Register 76, No. 6).

§ 2501. Purpose.

Compliance with and enforcement of Insurance Code Sections 380, 381, 383, 750 through 766, 780 through 784, 790 through 790.10, 1420, 11630 through 11663, 11730 through 11742, 11751.1 and 12921, and the regulations contained in this article are hereby declared to be necessary in the public interest to protect the rights of injured employees and their dependents, to protect prospective participating workers' compensation policyholders from misrepresentations and unfair practices concerning potential dividends, to prevent certain unfair and coercive practices in the payment of dividends, and to effectuate the purpose of the statutes governing the classification of risks and premium rates and policy and endorsement forms and the approval of such forms for workers' compensation insurance.

§ 2502. Relevant Statutes, Rules and Regulations.

All references to "section" herein refer to a section of the California Insurance Code unless otherwise stated.

Dividends: Workers' compensation insurers are authorized by Section 11738 to issue participating compensation policies. A dividend (refund) under such a policy can only be paid from surplus accumulated from premiums on workers' compensation policies issued pursuant to laws of California governing workers' compensation insurance. However, Section 1420 authorizes, in the case of reciprocal insurers, savings or credits to be returned to subscribers irrespective of the source from which such savings or credits accrue whenever such returns do not constitute an impairment of the assets or reserves required to be maintained.

Policy Forms: Under Section 11658, all workers' compensation policies and endorsement forms, including participating provisions relating to the payment of dividends thereunder, must be approved as to substance and form by the Commissioner prior to use. Rule III of the "Manual of Rules, Classification and Basic Rates for Workers' Compensation Insurance" (C.A.C. Title 10, Section 2350), provides that the entire contract of insurance, including any agreement with respect to participation thereunder, shall be set forth in the policy, including endorsements, and specifies that no agreement which is not set forth in such policy shall be valid or enforceable.

Rebate: Section 751 provides that an insurer, insurance agent, broker or solicitor, personally or otherwise, shall not offer or pay, directly or indirectly, as an inducement to enter into an insurance contract any valuable consideration which is not clearly specified, promised or provided for in the policy, or application for the insurance, and any such consideration not appearing in the policy is an unlawful rebate. Section 752 makes it a misdemeanor for the insured or any agent or representative of the insured to knowingly accept or receive any unlawful rebate. Section 763 provides that the payment of a dividend on a participating policy after expiration of the term covered by the policy is not an unlawful rebate.

Misrepresentation: Under Section 780 and Business and Professions Code Section 17500 it is unlawful for an insurance agent, broker or solicitor to misrepresent the terms or effect of an insurance policy or contract. Sections 780 and 782 make it a misdemeanor for any insurer or agent thereof, or an insurance broker or solicitor, to issue or permit to be issued, circulated or used, any misrepresentation of the terms of a policy, the benefits or privileges thereunder or the future dividends payable thereunder. Under Sections 783 and 783.5, an agent, broker or solicitor's license or an insurer's certificate of authority may be suspended, after hearing, for knowingly violating Section 780.

Unfair Practices: Section 790.03 prohibits the making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any

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misrepresentation as to the financial condition of any insurer. Section 790.10 empowers the Commissioner to promulgate, after notice and public hearing, reasonable rules and regulations necessary to administer the provisions of the Insurance Code dealing with unfair practices.

Rating Bureaus: Section 11751.1 provides that the California Inspection Rating Bureau shall not adopt any rule or exact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders or members.

Group Policies: Section 11656.6 provides that an insurer may issue a workers' compensation policy insuring an organization or association of employers as a group if such organization or association complies with certain conditions. One of the conditions specified in Section 11656.6 requires the organization or association to file certified copies of its articles of incorporation, by–laws or agreements of association and its rules and regulations governing the conduct of its business. Such documents must be filed with the Commissioner or a licensed workers' compensation rating organization designated by him. Section 11656.7 states that each member of an organization insured under a group policy shall be treated as a single and separate entity as respects rates, classifications and rating plan.

§ 2503. Participating Workers' Compensation Policies—Required Provisions and Notice of Intent to Issue.

Every prospective policyholder, including policyholders renewing existing policies, shall be entitled, on request, to written advice prior to the issuance of each policy, whether the policy is being issued on a participating or nonparticipating basis. Any such written advice shall be subject to the provisions of this article. Every workers' compensation policy issued on a participating basis shall include a participating provision or endorsement indicating that it is a participating policy. All workers' compensation policy forms, including any participating provisions or endorsements, must be approved as to substance and form by the Commissioner prior to use. If a policy is issued on a participating basis, the participating provision or endorsement must be designated "Participating Provision" and contain the following language:

"Under California Law it is unlawful for an insurer [us] to promise the future payment of dividends under an unexpired workers' compensation policy or to misrepresent the conditions for dividend payment. Dividends are payable only pursuant to conditions determined by the [our] Board of Directors or other governing board [of the Company] following policy expiration."

NOTE: Authority cited: Section 11659, Insurance Code. Reference: Sections 11657, 11658 and 11659, Insurance Code.

HISTORY

1. Amendment filed 12–30–83; operative 1–1–84 pursuant to Government Code section 11346.2(d) (Register 84, No. 1).
2. Editorial correction implementing 12–30–83 amendments and adding HISTORY 1 (Register 98, No. 40).

§ 2504. Representations Regarding Future Payment of Dividends.

No workers' compensation insurer or officer or agent thereof or insurance broker or solicitor shall represent, either orally or in writing, as an inducement either to insure or to continue or to renew insurance, that the insurer has agreed or will agree (a) to pay a specified policyholder's dividend or (b) upon a formula, criteria or factors which set forth or can be used to determine the amount of dividend, or percentage of premium to be paid as dividend, or amount or percentage of premium to be retained by the insurer after payment of dividend.

§ 2505. Dividend Statements.

(a) The employment of a "Policyholder Dividend Disclosure Statement" as hereinafter defined shall be mandatory in every circumstance that the annual premium, based upon the best information available, which will be earned during the policy period (the Estimated Annual Premium) shall equal or exceed the sum of $10,000. In all other circumstances, the employment of such "Dividend Statement" shall be optional at the discretion of the insurer. A workers' compensation insurer may advise a prospective policyholder, directly or through its agent or an insurance broker or solicitor, of the general provisions and factors, or the arrangement thereof, which are expected to be taken into consideration in regard to dividends on a given policy; provided that such provisions and factors shall not set forth or imply, directly or indirectly, the amount of dividend or percentage of premium which will be paid as dividend, or amount or percentage of premium to be retained by the insurer after payment of dividend. Any such advice or statement, whether issued directly to a prospective or current policyholder or issued by an insurer to its agent or a broker, shall be deemed a "Dividend Statement" and shall be subject to the rules set forth in this section.

(1) A Dividend Statement shall be upon a format prescribed by the Insurance Commissioner and available upon request from his San Francisco and Los Angeles offices. A Dividend Statement shall be in writing and shall include the mandatory language set forth in Section 2503 above. The mandatory language shall appear prior to, and have equal prominence as, any advice regarding such general provisions and factors set forth in the statement. Such Dividend Statement shall also contain, with equal prominence, the following language: "It is a misdemeanor for any insurer or officer or agent thereof, or any insurance broker or solicitor, to promise the payment of future workers' compensation dividends."

(2) A Dividend Statement shall include the rate or amount of dividend previously declared or paid on a similar policy or policies or the scale or schedule previously used to determine the amount or rate of dividends. In any such case, however, the Dividend Statement shall also set forth the period covered by policies on which such dividends were paid and that past dividend performance is no guarantee of an insurer's future dividend performance.

(3) A Dividend Statement shall set forth a time schedule during which the insurer intends to consider, compute or pay any dividend.

(4) A Dividend Statement shall include a statement in compliance with Section 2507.2 that forfeiture of a right to, reduction in the amount of, or delay in the payment of, a policyholder's dividend due to the policyholder's failure to accept renewal of the policy or subsequent policies issued by the same insurer is coercive and illegal and constitutes an unfair practice. This statement shall have equal prominence as any advice regarding such general provisions and factors set forth in the Dividend Statement.

(5) A Dividend Statement shall include a statement that, in every situation where the policy develops an annual premium equal to or in excess of the amount of $10,000 as finally audited and adjusted, a "Policyholder Dividend Result Disclosure Statement," which will provide all essential data employed to compute the dividend result, and which also will compare the factors actually employed in calculation of the dividend result to the factors presented to the policyholder in the Dividend Statement, shall accompany the dividend paid or, where no dividend is paid, shall be provided in place of a dividend.

(b) Whenever a workers' compensation policy has developed an annual premium equal to or in excess of the sum of $10,000 as finally audited and adjusted, a written form captioned "Policyholder Dividend Result Disclosure Statement" shall accompany the dividend paid or, where no dividend is paid, shall be provided in place of a dividend. This statement shall be upon a format prescribed by the Insurance Commissioner and available upon request from his San Francisco or Los Angeles office. The Policyholder Dividend Result Disclosure Statement must identify the policyholder and the insurer, the policy to which the statement applies, and the term of said policy. The Policyholder Dividend Result Disclosure Statement shall present the calculation of the dividend result, and shall provide the policyholder with all essential data provided to compute the dividend result. In the event that the insurer has also issued a Dividend Statement to the policyholder or his agent, broker, or solicitor in conjunction with the policy term for which the dividend is to be calculated and to which the Policyholder Dividend Result Disclosure Statement applies,

then and in such event the Policyholder Dividend Result Disclosure Statement must also compare the factors employed in calculation of the actual dividend result to the factors presented the policyholder when the policy was issued.

In presentation of the calculation of any dividend result, the Policyholder Dividend Result Disclosure Statement shall show such calculation in columnar form in both actual dollars and percentage of earned premium, and shall present such figures and percentages for the earned premiums, the incurred losses, the Incurred But Not Reported losses (IBNR), if any, the loss Development Factor (LDF), if any, the insurer retention, and any other factors pertinent to the actual dividend result. Within the context of this paragraph, the Incurred But Not Reported losses and the Loss Development Factor are deemed pertinent factors sufficient to warrant separate identification and disclosure, if applicable. In the event that the insurer has issued a Dividend Statement in conjunction with the policy term, the Policyholder Dividend Result Disclosure Statement shall also repeat these factors in actual dollars and percentages of estimated premium for comparison purposes and disclose any differences for the benefit of the policyholder.

(c) A Dividend Statement and Policyholder Dividend Result Disclosure Statement prepared in compliance with these sections shall be delivered to the organization or association or the administrator thereof in the event that the insurer will issue a workers' compensation policy insuring an organization or association of employers as a group in compliance with Section 11656.6 of the Insurance Code.

(d) If a policy of insurance is issued, continued or renewed and a Policyholder Dividend Disclosure Statement or Policyholder Dividend Result Disclosure Statement is issued in connection therewith by the insurer, a copy of such Dividend Statements shall be retained by the insurer with a copy of the policy, and shall be available for audit by the Insurance Department. Where the Dividend Statements are provided to the policyholder through an agent, broker or solicitor, such agent, broker or solicitor shall also retain a copy of the Dividend Statements with a copy of the policy.

(e) The provisions of this section relating to the mandatory form, content, delivery or retention of a Policyholder Dividend Disclosure Statement shall be applicable to workers' compensation policies incepting or renewing on and after April 1, 1985. The provisions of this section relating to the mandatory form, content, delivery or retention of a Policyholder Dividend Result Disclosure Statement shall be applicable to dividend results arising from a workers' compensation policy expiring on or after January 1, 1985.

NOTE: Authority cited: Sections 790.10 and 11734, Insurance Code. Reference: Sections 750, 763, 780, 790.02 and 11738, Insurance Code.

HISTORY

1. Amendment filed 4–2–85; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 85, No. 14).

§ 2506. Sanctions for Unfair Practices or Misrepresentations Regarding Workers' Compensation Dividends.

Any representation as to future dividends, or statements as to prior dividends declared or paid, issued by any insurer, agent, broker, or solicitor to induce a prospective policyholder to accept a policy, or to induce a policyholder to retain or renew a policy, failing to conform to this article shall be deemed an unfair practice or misrepresentation, subject to sanctions set forth in Insurance Code Sections 782, 783, 783.5 and 790.04 et seq.

§ 2507. Declaration by Board of Directors or Other Governing Board.

No right to a policyholder's dividend under a workers' compensation insurance policy, or to the application or use of any plan, scale, table, formula or schedule to determine whether any dividends shall be paid or allowed or the amount thereof, shall accrue unless and until the Board of Directors or other governing body of the insurer shall have determined that the insurer has a surplus from which dividends may lawfully be paid and shall have declared such dividends by resolution adopted after the expiration of the term covered by the policy.

Each declaration of policyholder's dividends for workers' compensation insurance policies by the Board of Directors or other governing board of the insurer shall identify by policy inception or expiration dates the body of policies to which such declaration is applicable and shall specify the dividend plans, scales, tables, formulas or schedules applied or to be applied to determine whether any dividends shall be paid or allowed or the amounts thereof to be allocated to separate policies pursuant to such declaration.

§ 2507.1. Prohibition Against Unfair Discrimination.

Allocation of dividends shall not be unfairly discriminatory. The dividend plans, scales, tables, formulas or schedules specified in the declaration may provide for allocation of dividends as a flat percentage of premiums or may provide for variations in the amounts of dividends or the percentages of premium paid as dividends based upon loss or expense factors or any other reasonable considerations, such as size, location, hazard, industry or trade classification, which have a probable effect on losses or expenses. Failure to apply in a consistent manner the plans, scales, tables, formulas or schedules adopted and specified in a declaration of dividends shall be prima facie evidence of unfair discrimination except that any variation from such adopted procedures set forth in a dividend statement, pursuant to Section 2505 hereof, which has been provided to the policyholder prior to inception of his policy shall not be deemed to be unfairly discriminatory.

§ 2507.2. Prohibition Against Unfair Forfeiture of Dividend for Failure to Renew.

(a) Forfeiture of a right to, reduction in the amount of, or delay in the payment of, a policyholder's dividend due to the policyholder's failure to accept renewal of the policy or subsequent policies offered by the same insurer is coercive and illegal and shall constitute an unfair practice.

(b) This section shall not be deemed to prohibit a reasonable reduction in the amount of a policyholder dividend if

(1) the policyholder has elected to be considered for policyholder dividends under a plan which utilizes the premium and loss experience of the policyholder for two or more policy years, and

(2) the nature of the adjustment is set forth in a Dividend Statement which has been provided to the policyholder within thirty days after the inception of the first policy year for which such election has been made, and

(3) the policyholder does not remain insured by the same insurer during the complete term of the multi–year dividend plan. In the context of this paragraph, a "reasonable reduction" in the amount of policyholder dividends is defined as and specifically limited to the application of that most favorable dividend plan for which the policyholder then qualifies under the dividend procedures of the insurer unless some alternative dividend plan has been set forth in the Dividend Statement provided the policyholder.

(c) Paragraphs (a) and (b) herein are effective with respect to all workers' compensation dividends declared or payable after the effective date hereof.

NOTE: Authority cited: Sections 790.10 and 11734, Insurance Code. Reference: Sections 750, 763, 780, 790.02 and 11738, Insurance Code.

HISTORY

1. Amendment filed 4–2–85; effective thirtieth day thereafter (Register 85, No. 14).

§ 2508. Group Policies—Reduction or Forfeiture of Member's Right to Distribution of Dividend Funds.

To avoid any coercion or possible misrepresentation of dividends which may be paid to members of organizations or associations of employers insured under group workers' compensation policies, no group policy shall be issued to become effective on and after July 1, 1976, unless the articles of incorporation, by–laws, agreements of association, or rules and regulations filed pursuant to Insurance Code Section 11656.6

shall provide that (1) any distribution of funds to any member, derived from a dividend, shall not be reduced or forfeited except for reasons set forth in the articles of incorporation, by–laws, agreements of association, or rules and regulations, and (2) no such reduction or forfeiture shall be made effective unless the reasons for such reductions or forfeiture have been made known by written communication to the member prior to inception of his insurance coverage during the policy period for which such dividend adjustment is made.

§ 2509. False or Deceptive Documents.

No workers' compensation insurer or officer or agent thereof, or other insurance broker or solicitor shall adopt or cause or permit to be issued, circulated or used any representation, plan, schedule, letter or advertising material of any kind stating or implying that any insurer has acted or will in the future act in any manner at variance with this article.

Article 9.5. Workers' Compensation Insurance Deposits

§ 2509.1. Application of Article.

This article applies to all insurers authorized to write workers' compensation insurance in this State.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

HISTORY

1. New Article 9.5 (Sections 2509.1–2509.20, not consecutive) filed 4–15–83; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 83, No. 16).

§ 2509.3. Purpose.

Insurance Code Section 11715 permits any workers' compensation insurer in lieu of filing the surety bond required by Section 11690 of the Insurance Code, to file a clean and irrevocable letter of credit with the Commissioner, or his approved depository, or to make an acceptable deposit of securities with a bank, savings and loan association or trust company, or to make a deposit with the State Treasurer. Deposits made with the State Treasurer, pursuant to Insurance Code Section 11715, are not governed by these regulations.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.4. Reporting of Transactions.

If the insurer elects to place the required deposit with a bank, savings and loan association or trust company, information shall be submitted to the Commissioner by the insurer and the depository, where applicable, on forms approved by the Commissioner.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.5. Classes of Securities Eligible for Deposit.

Debt securities, preferred stock and common stock, subject to the requirements set forth herein, are the only classes of investment securities eligible for deposit. Debt securities secured by interest in real estate are not eligible for deposit including but not limited to investments authorized under California Insurance Code Sections 1150, 1176, 1176.1, 1176.5, 1177, 1191.1, 1192.2, 1194.4, 1194.8, 1194.95.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.6. Acceptable Debt Securities.

Subject to the limitations set forth in the California Insurance Code and this Article, the following types of securities shall be acceptable to the Insurance Commissioner:

Issuing Entity	*Acceptable Type of Securities in NAIC Order*
(a) United States	Bonds or interest bearing notes or obligations or those for which faith and credit are pledged for the payment of principal and interest.
(b) Federal Agencies	Debentures and consolidated debentures or other debt securities specifically authorized for investment under the general investment sections of the California Insurance Code.
(c) Any state of the United States	All debt securities specifically authorized for investment under the California Insurance Code.
(d) A corporation organized under the laws of any state, or the United States, or District of Columbia, the Dominion of Canada or any Province of Canada.	Interest bearing obligations specifically authorized for investment under the California Insurance Code.
(e) Dominion of Canada, Commonwealth of Puerto Rico, any political subdivision of such commonwealth, any province of Canada.	All such debt securities specifically authorized for investment under the California Insurance Code.
(f) County, municipality or school district of any state of the United States, any Province of Canada or any political subdivision of the Commonwealth of Puerto Rico.	Any such debt securities, including California Road divisions bonds, specifically authorized for investment under the California Insurance Code.

Issuing Entity	*Acceptable Type of Securities in NAIC Order*
(g) A common carrier which is a corporation organized under the laws of any state, or the District of Columbia, the Dominion of Canada or any Province of Canada or a trustee for such corporation and investors, authorized to create a lien on transportation equipment.	Equipment trust obligations or certificates or other adequately secured instruments meeting the tests of Insurance Code Section 1192(b).
(h) Savings and loan associations and banks doing business in this state and insured by the Federal Savings and Loan Insurance Corporation or the Federal Deposit Insurance Corporation.	Investment certificates, passbook share accounts or savings accounts or other such interest bearing accounts specifically authorized for investment under the California Insurance Code.
(i) Any employer insured by the depositing insurer for its liability to pay workers' compensation insurance benefits.	Interest bearing promissory notes taken for premium, together with their supporting letters of credit or surety bonds, which meet the requirements of the Commissioner's regulations relating to promissory note premiums and collections as contained in Section 2350, Title 10, California Administrative Code.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.7. Debt Securities Defined.

Debt securities, as defined herein, include notes, bonds, debentures, or other instruments commonly used as instruments of indebtedness, and accounts, deposits, certificates and other investment securities issued by banks and savings and loans and specifically authorized for investment by insurers under the California Insurance Code; no debt securities will be acceptable for deposits if:

(a) the security is currently in default as to any principal or interest payments;

(b) the security or any security, lawfully issued by the same issuer, has been in default as to either principal or interest payments for more than ninety (90) days within the immediately past period of:

(1) two (2) years if the issuer is a county, municipality or school district in this State or in any other state, any province of Canada, or the Commonwealth of Puerto Rico; or

(2) ten (10) years if the issuer is this State or any other state.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.8. Debt Security Rating and Listing Requirements.

Any government debt security or non–government debt security listed on a national securities exchange which meets all other requirements in this Article and which has at least an "A3" rating by Moody's Investors Service, Inc., "A–" by Standard & Poor's Corporation, "A–" by Fitch Investors Service, Inc., or a comparable rating if the rating symbols are changed, is acceptable for deposit. Non–governmental debt securities which are traded over the counter and which meet all other requirements of this Article, must have at least an "Aa3" rating by Moody's Investors Service, Inc., "AA–" by Standard & Poor's Corporation or "AA–" by Fitch Investors Service, Inc. to be acceptable for deposit. Promissory notes as defined in Section 2509.6(i) or debt securities of banks and savings and loan associations need not meet the requirements contained in this section.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.9. Preferred Stock.

The following preferred stock is acceptable for workers' compensation deposits subject to the requirements set forth in this Article and the following conditions:

(a) the stock must be registered and traded on a national securities exchange as provided in the Securities Exchange Act of 1934, as amended; and

(b) within the last ten (10) years there must not have been arrears of dividend payments on such preferred stock; and

(c) the issuing corporation shall have paid dividends on its common stock in each of the last five (5) years of operation; and

(d) the issuing corporation shall have a net worth of at least one hundred million dollars ($100,000,000); and

(e) the issuing corporation shall not have incurred a net loss in any more than one (1) of the last five (5) years of operation; and

(f) the issuing corporation shall not have been in default on any of its indebtedness or any of its sinking fund requirements; and

(g) except in the case of sinking fund preferred stock, the preferred stock must have a rating of at least "a3" by Moody's Investors Service, Inc. or "A–" by either Standard & Poor's Corporation or Fitch Investors Service, Inc.; and

(h) sinking fund preferred stock must have a rating of at least "baa3" by Moody's Investors Service, Inc., "BBB–" by Standard & Poor's Corporation or Fitch Investors Service, Inc.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.10. Common Stock.

Common stock is acceptable for workers' compensation deposit subject to the requirements set forth in this Article, and all of the following requirements:

(a) the stock must be registered and traded on a national securities exchange as provided in the Securities Exchange Act of 1934, as amended; and

(b) the stock must not be stock of an affiliate of Applicant; and

(c) no more than ten percent (10%) of the deposited value shall be in the stock of any one corporation calculated on the basis of the minimum required deposit value which must be maintained by the depositing insurer; and

(d) the issuing corporation must have a net worth of at least one hundred million dollars ($100,000,000); and

(e) the issuing corporation shall have paid dividends on its common stock in each of the last five (5) years of operation; and

(f) the issuing corporation shall not have incurred a net loss in any more than one (1) of the last five (5) years of operation.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.11. Valuation of Securities.

Preferred and common stock are to be valued at market. All other securities, other than promissory notes taken for premium, for all purposes, shall be valued at the lower of par or market value. Promissory notes taken for premium shall be valued at the lowest of the following:

(a) the amount of written premium recorded by the insurer as of the valuation date less cash collected;

(b) the principal owed on the note; or

(c) the face amount of the supporting letter of credit or penal sum of the supporting surety bond.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.12. Time Limit on Valuation of Securities.

Securities which are being placed on deposit shall be valued as of a date no more than thirty (30) days prior to the date of delivery to the approved depository. Securities which are on deposit on December 31, shall be valued as of December 31.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.13. Required Value of Deposit.

(a) Generally.

The value of securities to be deposited with a bank, savings and loan association or trust company shall be not less than one hundred percent (100%) of the amount required to be maintained on deposit pursuant to Sections 11699 and 11715 of the California Insurance Code. No withdrawal of securities, including preferred and common stock, shall be made by the insurer which results in the total value of the deposit being less than one hundred percent (100%) of the required deposit amount. The insurer shall, at all times, have on deposit sufficient securities to maintain the deposit value at not less than one hundred percent (100%) of the required amount.

(b) Promissory Notes Taken for Premiums —Additional Restrictions.

(1) The total deposit value of all promissory notes taken for premium and which are placed on deposit with a bank, savings and loan association or trust company may not exceed fifty percent (50%) of the amount required to be maintained on deposit by Sections 11699 and 11715 of the California Insurance Code.

(2) The insurer shall report quarterly to the Insurance Commissioner in a form prescribed by the Commissioner with regard to promissory notes taken for premium and which are placed on deposit with a bank, savings and loan association or trust company.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11699 and 11715, Insurance Code.

§ 2509.14. Election of Depository.

(a) Any workers' compensation insurer electing to deposit securities in the California office of a duly licensed bank, savings and loan association or trust company shall do so subject to the approval of the Commissioner. The selected Depository shall have deposits of no less than seven hundred fifty million dollars ($750,000,000). If such election is made, no more than one (1) office of any bank, savings and loan association or trust company shall be selected as the holder of the required deposit. The holder is defined herein as the center of control and reporting. All records pertaining to the deposit shall be maintained in the selected holder–office. The deposited assets shall be maintained in this State.

(b) Where a depository is used, the outside depository trust company shall be approved in advance for such purpose by the Commissioner. In such a case, book–entry accounting is acceptable for the deposit. The Federal Reserve book–entry program for deposit of federal securities may be issued through the Depository itself because it is (1) a member bank in the Federal Reserve System located in California or (2) a depository institution which has its own direct account at the Federal Reserve System located in California, whether or not the definitive certificates are available upon express request. The Depository shall monitor the transactions and maintain the book–entry securities. It shall expressly undertake the same responsibilities, obligations, duties and reporting requirements for these securities as for all other deposited securities.

(c) Subject to the bank, savings and loan association or trust company's right to terminate the agreement pursuant to which a deposit is held, no insurer may change its election more frequently than once in any twelve (12) month period. Any change in Depository shall be subject to the prior approval of the Commissioner. Notwithstanding the foregoing, an insurer may elect to file a workers' compensation bond or a letter of credit with the Commissioner, or make a securities deposit with the State Treasurer.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

HISTORY

1. Amendment of subsection (b) filed 8–28–98; operative 9–27–98 (Register 98, No. 35).

§ 2509.15. Title and Location of Deposit Held by a Depository.

If an insurer elects to place the required deposit with a bank, savings and loan association or trust company, all securities shall be in coupon or bearer form, negotiable form, registered to the Insurance Commissioner, or in the name of the depository bank, savings and loan association or trust company, or in the name of a nominee of such bank, savings and loan association or trust company, and shall be in accordance with the laws of this State permitting use of nominees. If registered in the depositor's name, the workers' compensation insurer shall execute and deliver, in duplicate, to the Commissioner a power of attorney in favor of the Commissioner for the purposes specified in Section 11690 of the California Insurance Code supported by a resolution of the depositor's board of directors. In the case of the deposit of a promissory note taken for a premium, the power of attorney and resolution of the board of directors shall extend to the promissory note and the supporting letter of credit or surety bond. Such power of attorney and directors' resolution shall be on a form approved by the Commissioner, and shall provide that the power of attorney cannot be revoked or withdrawn without the consent of the Commissioner, and shall contain an acknowledgment, as required by law.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11690 and 11715, Insurance Code.

§ 2509.16. Approval by Commissioner of Depository Agreement.

If an insurer elects to maintain the required deposit with a bank, savings and loan association or trust company, the written agreement with the insurer and the bank, savings and loan association or trust company, and the Commissioner shall be substantially in the form set forth in Section 2509.17 of these regulations and shall be filed with and approved by the Commissioner.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.17. Form of Agreement.

DEPOSITORY AGREEMENT

THIS AGREEMENT is made and entered into at _____, California, on _____,19____,by and among

_____,

(Insurer)

an insurer authorized to write workers' compensation insurance in the State of California, hereinafter called "Insurer,"

_____

(Name of Bank, Savings and Loan Association or Trust Company)

_____

(Address)

authorized to carry on business in the State of California, hereinafter called "Depository" and the Insurance Commissioner of the State of California, hereinafter called "Commissioner."

WHEREAS, workers' compensation insurers writing such insurance in the State of California are authorized to establish a deposit and enter into a depository agreement with a bank, savings and loan association or trust company under Section 11715 of the Insurance Code and regulations set forth in Article 9.5, Subchapter 3, Chapter 5, Title 10, of the California Administrative Code, and

WHEREAS, said deposit placed pursuant to the requirements set forth in Sections 2509.1 through 2509.20, Title 10, of the California Administrative Code, may be retained by a bank, savings and loan association or trust company duly–licensed in California, and

WHEREAS, the Depository qualifies as such a bank, savings and loan association or trust company and is duly–licensed in California.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

ARTICLE 1
DEPOSIT

Insurer deposits with Depository and Depository accepts the securities set forth in Schedule "A," attached hereto and made a part hereof, hereinafter called "deposit." In accepting said deposit, Insurer and Depository agree to abide by the terms herein, the California Insurance Code, and Article 9.5, Subchapter 3, Chapter 5, Title 10, of the California Administrative Code.

ARTICLE II
DUTIES AND POWERS

A. Depository agrees to render to the Commissioner a report, as of December 31st, and at any time upon the request of the Commissioner, but in no event to exceed ten (10) business days from the date of request, containing an accounting identifying and listing the deposit. All accounting shall be certified to be true and correct according to the best information and belief of the Depository.

B. Current deposit value for securities shall be the lower of par or market, except that preferred stock and common stock are to be valued at market value. As respects promisory notes which are placed on deposit, the Depository may rely, in good faith, upon representations of the Insurer as to the deposit value of such notes. All valuations must be made within thirty (30) days prior to submission of the report. All accounting shall be certified to be true and correct according to the best information and belief of the Depository.

C. The Depository shall indemnify the Insurer for any loss, damage or injuries sustained by the Insurer with respect to any securities deposited pursuant to this Agreement including loss occasioned by employee dishonesty, burglary, robbery, theft or mysterious disappearance, unless such loss should be caused by nuclear contamination from a cause other than the industrial use of nuclear energy, expropriation by governmental authority, war, insurrection or revolution. The Depository agrees that if there is a loss of securities in its custody, the Depository will replace them or the monetary value thereof, and the monetary value of any loss of rights or privileges resulting from said loss of securities, within ten (10) business days, unless, pursuant to an agreement with the Commissioner extra time is granted, from the date that said securities cannot be accounted for by the Depository. Also, immediately upon discovery, the Depository shall notify the Commissioner of the loss and the proposed action to be taken by the Depository in connection therewith.

D. The Depository agrees to hold said deposits separate from its own assets and all of the deposits held by it, except where it uses the Federal Reserve Bank book–entry account, or, where it has its own internal FOSBI system (filing of securities by issuer), or uses an outside depository trust company previously approved by the Commissioner, which maintains its records and the insurer's deposit in this State. In using such outside depository, the Depository herein agrees to and is obligated to indemnify the Insurer for loss or damage based upon the actual omissions of its agent (here the depository utilized by the institutional Depository) so as to protect the Insurer's deposit in connection with such transaction. The Depository agrees that it shall assume the same responsibility and liability to the Insurer for the loss of such securities in connection with the entrusting to and handling of the securities by the outside depository, to the same extent that the Depository would be responsible for his handling of the securities directly and exclusively. Insurer assigns its rights, if any, to recover from the outside depository to the Depository in return for this indemnification and agrees that it will provide reasonable assistance to the Depository in order that the Depository may recover any loss or liability from the outside depository.

E. (For use where ownership is evidenced by credit on the books of account and records in the Federal Reserve Bank.) Said Depository, in the exercise of its powers as such Depository, has caused to be credited in its name on the books and records of the Federal Reserve Bank the sum of $_____, representing the face amount of eligible United States Government and Agency securities listed in Schedule "B" attached hereto and made a part hereof, hereinafter called "deposit." The Depository represents to all parties hereto that such schedule is a true and complete statement of the eligible United States Government and Agency securities included among the total of such securities held in a "General" book–entry account maintained in the name of such Depository on the books and records of the Federal Reserve Bank as of the close of business on ____. The Depository undertakes to clearly indicate in its books and records the purpose of this deposit.

F. Insurer shall submit and Depository shall accept for deposit such securities, including preferred and common stock, only in coupon or bearer form, negotiable form, registered to the Insurance Commissioner, or in the name of the Depository, or in the name of a nominee of such Depository, or its agent in accord with the laws of this State permitting use of nominees. If registered in the Insurer's name, the securities must be accompanied by a power of attorney and a board of directors' resolution on forms approved by the Commissioner, as set forth in the Insurance Commisisoner's Securities Transactions Instructions, and as required by Section 2509.15, Title 10 of the California Administrative Code.

G. Insurer agrees to submit for deposit only such securities as are acceptable for deposit pursuant to Article 9.5, Subchapter 3, Chapter 5, Title 10 of the California Administrative Code.

H. At any time, Insurer may substitute approved securities of at least equal value for those held by the Depository or place additional securities on deposit in accordance with the requirements set forth herein. Insurer shall certify that the substituted or additional deposit is in compliance with Section 943, 944, 951 and 11715 of the California Insurance Code and Article 9.5, Subchapter 3, Chapter 5, Title 10 of the California Administrative Code. The certification shall be signed by two (2) authorized officers of the Insurer and submitted to the Depository.

Withdrawal without replacement is permitted only with the Commissioner's prior written approval.

The Depository shall have no responsibilities with respect to the investment and reinvestment of the property held by it under this Agreement. All sales, purchases, exchanges or other transactions respecting securities or other property which may be made by the Depository for the account of the Insurer shall be made only pursuant to instructions of the Insurer of the Insurer's designated representative except upon written request of the Commissioner, pursuant to Article I, Chapter 3, Part 3, Division 2 of the California Insurance Code to immediately assign and deliver to the Commission upon demand any and all securities deposited or held under the terms of this Agreement. Absent such instructions, the Depository shall have no responsibility for the investment or reinvestment of such property nor liability for any omission to act in the absence of instructions.

The Insurer and not the Depository shall be responsible for all property held under this agreement paid and/or delivered to any broker or other person specified by Insurer in such manner as Insurer may direct. The Depository is directed to sell all fractional shares received by it unless notified to the contrary by the Insurer. The Depository shall not vote proxies. All proxies shall be forwarded to the Insurer.

The Depository shall either reinvest net income or distribute it as Insurer may direct from time to time. The Depository shall distribute principal cash as Insurer may direct from time to time. Securities may likewise be withdrawn pursuant to such direction subject to qualification that the Depository may retain such funds and securities as it determines to be necessary to complete any pending buy or sell transactions. The Depository shall prepare a monthly statement, in the usual form for accounts of this type and shall deliver the same to The Insurer and to any representative designated by Insurer.

I. The Insurer shall furnish to the Commissioner and the Depository its determination of its current deposit requirements under Sections 11690 through 11715 of the California Insurance Code, prior to the effective date of this Agreement, and thereafter on the same basis as reported to the Commissioner on Schedule P, as of December 31st, of each year.

J. Written notice of the same or substitution of any security or the deposit of additional security as well as an accounting which reflects a deposit value of the security being placed on deposit shall be prepared by the Insurer and signed, sealed and dated by two (2) authorized officers of the Depository and shall be provided to the Commissioner by the Depository within ten (10) business days of the settlement or deposit date.

K. Depository will, at all times and without prior notice, make available its books and records of such deposit held under this Agreement for audit, examination and inspection by the Insurer or by the Commissioner.

L. Insurer hereby directs and Depository agrees, upon written request of the Commissioner, pursuant to Article I, Chapter 3, Part 3, Division 2 of the California Insurance Code to immediately assign and deliver to the Commissioner upon demand any and all securities deposited or held under the terms of this Agreement.

M. Depository agrees that it shall not and does not have the power to use, pledge, invest, encumber or subject said deposit to any lien or claim by Depository.

ARTICLE III
EXCULPATORY CLAUSES

A. Other than under the terms of any instrument deposited pursuant to the terms of this Agreement, Depository shall not be under any liability for payment of interest on a deposit made hereunder.

B. Depository shall be entitled to reasonable compensation from Insurer for all services, ordinary and extraordinary, rendered by it pursuant to the terms of this Agreement, including reasonable attorneys' fees for services of counsel. Depository shall not be required to comply with any direction of the Insurer which in its judgment may subject it to liability or expense, or to prosecute or defend any action, unless indemnified in a manner and amount satisfactory to it.

C. Depository may terminate this Agreement and become and remain fully discharged from all further duties and liabilities hereunder upon giving at least sixty (60) days notice by certified mail in writing to the Insurer and the Commissioner. Insurer may terminate this Agreement by giving at least sixty (60) days notice by certified mail in writing to the Depository and the Commissioner. In such event, any successor Depository shall be appointed in the same mode and manner as provided for under Sections 11690 through 11715 of the California Insurance Code, Article 9.5, Subchapter 3, Chapter 5, Title 10 of the California Administrative Code and as hereinafter provided in Paragraph D next following.

D. Upon the effective date of termination and withdrawal of the deposit, Insurer shall deliver, in the required amount, a workers' compensation bond, as set forth under California Insurance Code Section 11690, a letter of credit to the Commissioner of the deposit of securities with any other approved depository, as set forth in Section 11715 of the California Insurance Code, all in compliance with the requirements set forth herein, the California Insurance Code, and the regulations of the Insurance Commissioner set forth in Article 9.5, Subchapter 3, Chapter 5, Title 10 of the California Administrative Code, and pursuant to the prior written approval of the Commissioner.

ARTICLE IV
MISCELLANEOUS

A. Nothing in this Agreement shall give, or be construed to give, any person, firm or corporation, other than the parties hereto, any legal or equitable right, remedy or claim under this Agreement or under any covenant or provisions contained herein, all the covenants and provisions being for the sole benefit of the parties hereto.

B. Depository affirms, to the best of its knowledge and belief that said securities are owned by the insurer and are free and clear of all liens, claims and encumbrances and do not constitute security for any loans.

C. This Agreement shall be executed in quadruplicate and each copy shall be deemed an original; two (2) copies shall be submitted to the Commissioner.

D. All notices, requests, consents and other communications, required or permitted with respect to the Agreement, shall be in writing and shall be addressed as follows:

Insurer:

Depository:

Insurance Commissioner

State of California:

IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

_____

By _____

(Seal) By _____
Insurer

_____

By _____

(Seal) By _____
Depository
Commissioner of Insurance
State of California

(Seal) By _____

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Sections 943, 944, 951 and 11690 through 11715, Insurance Code.

§ 2509.18. Letter of Credit.

The Commissioner will accept, in lieu of deposited securities or a surety bond, a letter of credit acceptable to and filed with the Commissioner or his approved depository, which is in full compliance with the following:

(a) Two (2) originally signed copies must be submitted, one (1) of which will be returned to the issuing bank for verification of signature authorization;

(b) The issuer must be a member bank of the Federal Reserve System with an office in this State;

(c) The beneficiary must be the Insurance Commissioner of the State of California;

(d) It must be clean and irrevocable and comply with the following:

(1) It must be an unconditional letter requiring no documentation; the beneficiary must be able to realize funds simply by drawing a draft under the credit, limited only by the amount available, as set forth in the letter of credit; and

(2) It must be expressly stated that it is clean and irrevocable and that it cannot be modified or revoked without the consent of the beneficiary, once the beneficiary is established; and

(3) It must contain an "evergreen" clause which prevents expiration of the letter of credit without some affirmative action by the issuer; the letter must be for not less than one (1) year and must provide that it will be automatically extended for the period of time stated in the original letter if the notice of expiration is not complied with by the issuer; the Commissioner–beneficiary and the insurer–account holder must be given no less than forty–five (45) days prior notice of the expiration of such letter of credit.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.19. Permitted Combination.

The Commissioner will accept, in lieu of a surety bond, a combination consisting of a letter of credit filed with him and a deposit of securities to meet the statutory deposit requirements set forth and referenced in California Insurance Code Section 11715. If such combination is used, a separate fee for review must be paid for the deposit and the letter of credit. If a surety bond is filed, no combination deposit may be used.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.20. Withdrawal of the Commissioner's Authorization in the Event of Non–Compliance.

In the event that the Commissioner determines that an insurer or depository has not fully complied with this Article, to the extent applicable to such insurer or depository, the Commissioner may withdraw any authorization granted and order such insurer to transfer all of its deposit to the Commissioner or other depository designated by the Commissioner.

NOTE: Authority cited: Section 11715, Insurance Code. Reference: Section 11715, Insurance Code.

§ 2509.21. Deposits of Reinsurers.

(a) When an admitted insurer is subject to proceedings specified in Insurance Code Sections 11698(a) or 11698.3, any workers' compensation deposit made pursuant to Insurance Code Section 11691(f)(1) by any re-

insurer of the insurer, which the reinsurer was required to identify to the commissioner pursuant to Insurance Code Section 11691(f)(1) and for which the ceding insurer was allowed any deposit credit, shall be deemed for the purposes of Article 1 (commencing with Section 11690), Chapter 3, Part 3, Division 2 of the Insurance Code, to be included as part of the ceding insurer's own workers' compensation deposit pursuant to Insurance Code Section 11691(a). The commissioner shall use the proceeds of any such deposit by the reinsurer, and any interest thereon, only for the payment of that portion of a workers' compensation claim which the reinsurer is required to pay as determined pursuant to Insurance Code Section 11691(f)(2). To the extent that any portion of a reinsurer's deposit is used to pay a compensable workers' compensation claim against an insurer as provided in the preceding sentence, the liability of the reinsurer with respect to the portion of the claim so paid shall be deemed fully satisfied and released. Upon request, the commissioner shall provide to any reinsurer a special certificate pursuant to Insurance Code Section 12973 that memorializes the satisfaction and release.

(b) By reason of the reinsurance agreement requirements set forth in Insurance Code Section 11691(f)(2), payment of a claim from a reinsurer's deposit shall be considered an authorized payment to an alternative payee for the purposes of Insurance Code Section 922.2(a)(2).

NOTE: Authority cited: Section 11691, Insurance Code. Reference: Sections 922.2, 11691, 11698 and 11698.3, Insurance Code.

HISTORY

1. New section filed 7–10–2006; operative 8–9–2006 (Register 2006, No. 28).

Article 9.6. Workers' Compensation Rate Filings

§ 2509.30. Purpose.

This subchapter is adopted to implement the provisions of Insurance Code Sections 11730 through 11759.1, which, among other matters, govern insurance company filing of workers' compensation insurance rates and rating plans, and to specify the handling of those filings by the Commissioner.

HISTORY

1. New article 9.6 and section filed 10–13–94; operative 10–13–94. Submitted to OAL for printing only pursuant to Statutes of 1993, Ch. 1242 (S.B. 223), section 43, subdivision 3 (Register 94, No. 41).

§ 2509.31. Definitions.

(a) "Actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries who meets the general qualification standard to present public statements of actuarial opinion.

(b) "Approved pure premium rates" means the pure premium rates prepared and submitted by the designated rating organization and approved by the Commissioner.

(c) "Commissioner" means the Insurance Commissioner of the State of California.

(d) "Deviation" means the insurer's adjustment, upward or downward, of the approved pure premium rates based only on charges in the loss cost per unit of exposure, including loss adjustment expense.

(e) "Pure premium rate modifier" means all the factors, other than deviations, if any, by which an insurer adjusts the approved pure premium rates or its independently developed pure premium rates to arrive at that insurer's filed rates.

(f) "Rating plan" means the rules and numeric values an insurer uses to calculate the premium for an insured.

HISTORY

1. New section filed 10–13–94; operative 10–13–94. Submitted to OAL for printing only pursuant to Statutes of 1993, Ch. 1242 (S.B. 223), section 43, subdivision 3 (Register 94, No. 41).

§ 2509.32. Insurer's Rate Filing.

(a) Insurance Code Sections 11734 and 11735 require an insurer to file its rates and supplementary rate information at least 30 days before their effective date, unless the Commissioner approves the insurer's request for an earlier date. Insurance Code Section 11658 provides that no insurer shall issue a workers' compensation insurance policy unless the policy is first approved by the Commissioner. Insurers shall file workers' compensation insurance rate filings with the Department of Insurance, Rate Filing Bureau for Workers' Compensation Insurance.

(b) The filing date of a rate filing is the date the Rate Filing Bureau for Workers' Compensation Insurance receives a complete rate filing. The 30–day waiting period described in Insurance Code Section 11734, subdivision (b), and Section 11735, subdivision (a), begins on the filing date.

(c) The Commissioner shall determine whether a rate filing is complete and complies with filing requirements, and the Commissioner may reject a rate filing if the insurer fails to comply with filing requirements or if the filing is incomplete.

(1) If the Commissioner rejects an insurer's rate filing because it is incomplete or otherwise fails to comply with filing requirements, any subsequent rate filing by that insurer shall be given a new filing date on its receipt by the Rate Filing Bureau for Workers' Compensation Insurance.

(2) If a rate filing needs correction of an error or filing of additional information to be complete, the Commissioner shall give the insurer an opportunity to correct the filing. If the insurer corrects the rate filing within 30 days of its original filing date, the insurer may calculate the 30–day waiting period from the original date of the rate filing. If the insurer corrects the rate filing more than 30 days from its original filing date, the Department shall assign a new filing date, which shall be the date the correction or additional information is received by the Rate Filing Bureau for Workers' Compensation Insurance. In that case, the insurer may request of the Commissioner that its rates become effective earlier than the normal 30–day waiting period.

(d) Every insurer that makes a rate filing shall complete the Workers' Compensation Insurance Rate Filing Form ("Filing Form") provided by the Department of Insurance. The Filing Form shall be prescribed by the Commissioner. No rate filing shall be complete without a completed Filing Form.

(e) A complete rate filing is one for which the insurer has completed the Filing Form and submitted all necessary attachments and exhibits. Necessary attachments and exhibits are those materials that, together with the Filing Form, are sufficient to enable the Commissioner to determine the rates the insurer would charge its insureds. Unless the Commissioner notifies the insurer within 30 days of the filing date that its rate filing is incomplete, the rate filing will be considered complete.

(f) The insurer shall specify its pure premium rate modifier on the Filing Form.

(g) The insurer may request that any or all of its pure premium rate modifiers and deviations remain on file with the Commissioner and be applicable to subsequent approved pure premium raters. If the insurer makes that request, the following conditions shall apply:

(1) If the insurer chooses to use subsequent approved pure premium rates when they become effective, and has so indicated on the Filing Form, the insurer need file nothing additional with the Department before using those rates. Under that circumstance, the insurer's new rates will be the combination of the new approved pure premium rates and the insurer's previously filed pure premium rate modifications and deviations, if any.

(2) If the insurer chooses to use the subsequent approved pure premium rates but with a different effective date than that specified by the Commissioner, the insurer shall notify the Department of the intended effective date no less than 30 days before their actual use by the insurer, unless the Commissioner approves the insurer's request for an earlier effective date.

(h) If an insurer chooses not to apply any its pure premium rate modifiers and deviations to subsequent approved pure premium rates, it shall so indicate on the Filing Form.

(i) An insurer that wishes to adopt the approved pure premium rates or other filings of the designated rating organization shall specify the rates or other filings it is adopting and, by that reference, may incorporate

those rates or other filings into its filing. Every insurer shall adhere to the experience rating plan and uniform statistical reporting plan filed by the designated rating organization and approved by the Commissioner.

(j) An insurer shall accompany each rate filing with a statement of opinion by an actuary regarding whether the filing rates include a reasonable estimate of the insurer's expected losses and expenses for the anticipated risks for the periods the insurer intends to use the filed rates.

(k) If an insurer files a classification system different from the standard classification system developed by the designated rating organization and approved by the Commissioner as part of the uniform statistical reporting plan, the insurer shall explain in detail how its classification system differs from the uniform classification system.

(1) The insurer's classification codes shall be compatible with the classification codes of the uniform classification system.

(2) The insurer shall demonstrate that the data produced by its classification system can be reported consistent with the uniform statistical reporting plan and uniform classification system. The Commissioner will accept in lieu of the insurer's demonstration a written certification from the designated rating organization that data produced by an insurer's classification system can be reported consistent with the uniform statistical reporting plan and the uniform classification system.

HISTORY

1. New section filed 10–13–94; operative 10–13–94. Submitted to OAL for printing only pursuant to Statutes of 1993, Ch. 1242 (S.B. 223), section 43, subdivision 3 (Register 94, No. 41).

§ 2509.33. Disapproval of an Insurer's Rates; Procedure.

(a) The Commissioner may commence a rate disapproval hearing by serving a notice of hearing on the insurer. The hearing notice shall state which parts of an insurer's rate filings the Commissioner proposes to disapprove and shall specify in reasonable detail the reasons for any proposed disapproval. The hearing notice shall state the date and location of the hearing. A hearing shall be commenced within a reasonable time after issuance of the hearing notice.

(b) The decision of the hearing officer shall be based on the record of the proceedings. The record of the proceedings shall consist of the written pleadings submitted by the parties, any oral testimony, the documentary evidence admitted into evidence by the hearing officer, and if a written transcription of the proceedings is made by a Certified Shorthand Reporter, the written transcription.

(c) A disapproval of a rate filing other than a rejection for incompleteness as specified in section 2509.32, subdivision (c), shall occur only by order of the Commissioner after a hearing. If the Commissioner disapproves a rate, the order shall specify when, within a reasonable time after the decision, the rate shall no longer be used.

(d) All documents admitted as evidence in the hearing shall be open to public inspection.

(e) If after a hearing the Commissioner disapproves an insurer's rate filing, it shall not have any legally effective rates. The Commissioner shall specify interim rates upon the insurer's request.

(f) If the Commissioner rejects an insurer's rate filing because of incompleteness or for failure to comply with filing requirements, its legally effective rates shall be the prior rates in effect for the insurer. "Prior rates" means the rates properly in effect for the insurer at the time of its incomplete filing.

(g) The Commissioner may serve any document concerning a rate disapproval hearing in the manner provided in Section 1013, subdivision (a), of the California Code of Civil Procedure. The address for service on an insurer shall be the address of the insurer's agent for service of process in the State of California.

(h) An insurer may serve any document concerning a rate disapproval hearing as provided in Section 1013, subdivision (a), of the California Code of Civil Procedure. The address for service on the Commissioner shall be his or her address in San Francisco.

HISTORY

1. New section filed 10–13–94; operative 10–13–94. Submitted to OAL for printing only pursuant to Statutes of 1993, Ch. 1242 (S.B. 223), section 43, subdivision 3 (Register 94, No. 41).

§ 2509.34. Disapproval of an Insurer's Rates; Notices to Insured.

Every workers' compensation policy incepting on or after January 1, 1995, shall contain a provision that the premium may be subject to mid-term adjustment, for the unexpired term of the policy, pursuant to the Commissioner's power to disapprove rates.

HISTORY

1. New section filed 10–13–94; operative 10–13–94. Submitted to OAL for printing only pursuant to Statutes of 1993, Ch. 1242 (S.B. 223), section 43, subdivision 3 (Register 94, No. 41).

Article 9.7. Workers' Compensation Insurance Procedural Requirements and Standards Applicable to Employers, Insurers, and Rating Organizations in the Initiation of and Response to Requests for Review, Requests for Policyholder Information, and Requests for Reconsideration Provided in Insurance Code Sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b), and, Rules of Practice and Procedure for Appeals to the Insurance Commissioner Pursuant to Insurance Code Sections 11737(f), 11752.6(c), 11753.1(a), 11753.1(b) and 11753.1

§ 2509.40. Scope.

This article sets forth the procedural requirements and standards applicable to employers, insurers, rating organizations and other persons in the initiation of and response to requests for review, requests for policyholder information, and requests for reconsideration provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b), found in Articles 2 and 4 of Chapter 3 of Part 3 of Division 2 of the California Insurance Code, entitled "Regulation of Business of Workers' Compensation Insurance." This article also sets forth the rules of practice and procedure governing appeals to the Insurance Commissioner and proceedings conducted pursuant to Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b). The regulations set forth in this article supersede any previously adopted regulations regarding complaints and appeals to the extent that such previously adopted regulations are inconsistent with these regulations.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c) and 11753.1, Insurance Code.

HISTORY

1. New article 9.7 (sections 2509.40–2509.78) and section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New article 9.7 (sections 2509.40–2509.78) and section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New article 9.7 (sections 2509.40–2509.78) and section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New article 9.7 (sections 2509.40–2509.78) and section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending section and NOTE filed 1–2–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 1).

7. Change without regulatory effect amending article heading and amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.41. Purpose.

(a) The purpose of this article is to establish a clear and consistent process for the initiation of requests for review, policyholder information, and reconsideration, and the responses thereto, provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).

(b) The purpose of this article is also to establish a clear and consistent process for the disposition of appeals to the Insurance Commissioner provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c) and 11753.1, Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending section and NOTE filed 1–2–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 1).
7. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.42. Definitions.

The following definitions shall apply to this article.

(a) "Appeal" means a written appeal to the Insurance Commissioner pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).

(b) "Appellant" means the party filing an appeal pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).

(c) "Commissioner" means the Insurance Commissioner of the State of California.

(d) "Complaint and Request for Action" means:

(1) The written request of an employer or other aggrieved person seeking an insurer's or rating organization's review of the manner in which the rating system has been applied in connection with the insurance afforded or offered, pursuant to subdivision (f) of Insurance Code section 11737.

(2) The written request of any employer insured under a workers' compensation insurance policy, served upon a licensed rating organization, for any or all policyholder information relating to the employer, as defined Insurance Code section 11752.6(b).

(3) The written request of an employer, insurer or other person seeking reconsideration of a decision, action, or omission to act of a rating organization, pursuant to Insurance Code section 11753.1(a).

(4) The written request for reconsideration of an employer, in response to receipt of the notice required by Insurance Code section 11753.1(b) concerning a change in the classification assignment of the employer that results in an increased premium.

(e) "Day," unless otherwise specified in these regulations, means a calendar day. "Business days", if specified, include all days except Saturdays, Sundays, and any holiday set forth in California Government Code section 6700. The time within which any document may be filed or served shall exclude the first day and include the last day; however, when the last day falls on a Saturday, Sunday or holiday the time computation shall exclude that day and include the next business day.

(f) "Department" means the California Department of Insurance.

(g) "Employer" means a person or business entity currently or formerly insured under a workers' compensation insurance policy or a person or business entity seeking such insurance coverage.

(h) "Filing" means the act of delivery of a pleading to the Department by 4:30 p.m. local time on any due date. Pleadings may be filed by facsimile transmission with the prior approval of the Department. All filed pleadings shall be accompanied by an original declaration of service. An employee of a party, or other representative of a party may sign a declaration of service. A sample declaration of service form can be found in section 2509.78.

(i) "Hearing" and "Proceeding" mean the hearing provided by Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b), found in Articles 2 and 4 of Chapter 3 of Part 3 of Division 2 of the California Insurance Code, entitled "Regulation of Business of Workers' Compensation Insurance.

(j) "Hearing Officer" means the Department representative appointed by the Commissioner to preside over the hearing.

(k) "Party" means the appellant or respondent in an appeal to the Insurance Commissioner and any other person allowed to intervene or participate in the proceeding.

(*l*) "Pleading" means any appeal, answer, motion, reply, request, response, evidence, exhibit, brief, request for reconsideration, or other document filed with the Administrative Law Bureau pursuant to this article.

(m) "Rating Organization" means an entity licensed by the Commissioner pursuant to Insurance Code section 11751. "Designated Rating Organization" means that rating organization designated as the Commissioner's statistical agent pursuant to Insurance Code section 11751.5.

(n) "Reasonable Time" in relation to a complaint and request for action filed pursuant to Insurance Code sections 11753.1(a) and (b), and Insurance Code Section 11752.6(c) means within thirty (30) days of service of written decision rejecting a request for reconsideration or a request for policyholder information, or, if no timely rejection is served, one hundred and twenty (120) days from the date of service to the rating organization or insurer of the request for reconsideration or the request for policyholder information, unless the time limit for granting or rejecting a request has been extended pursuant to Section 2509.46.

(o) "Respondent" means an insurer or rating organization that is the subject of an appeal filed pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).

(p) "Service" in relation to the hearing, means to provide a copy of a document to every other party in the proceeding by personal delivery, first–class mail, registered mail, by mail delivery service, or, with permission of the Commissioner or the hearing officer, by facsimile transmission that is without error. Documents served on insurers or the designated rating organization shall be sent to an office designated for such service pursuant to Section 2509.43(a), below. When a party files a document, the party shall concurrently serve that document on all other parties in the proceeding. All served documents shall be accompanied by a copy of a declaration of service. Service by first class mail, registered mail or mail delivery service is complete at the time of deposit with the carrier, but any prescribed period of notice and any right or duty to do any act or make any response within any prescribed period or on a date certain after the service of the document served shall be extended for a period of five days.

(q) "Service" or "Serve" with regard to correspondence and action prior to the filing of an appeal, means to personally deliver a writing, response, decision or notice, or send such documents by first–class mail, registered mail, by mail delivery service or by facsimile transmission that is without error. Documents served on insurers or the designated rating organization shall be sent to an office designated for such service pursuant to Section 2509.43(a), below. Service by first class mail, registered mail or mail delivery service is complete at the time of deposit with the carrier, but any prescribed period of notice and any right or duty to do any act or make any response within any prescribed period or on a date certain after the service of the document served shall be extended for a period of five days.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending subsections (a), (b), (d)(1), (i) and (o) and amending NOTE filed 1–2–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 1).
7. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.43. Complaints and Requests for Action. Office Designated for Receipt of Complaints and Requests for Action.

(a) Every insurer and rating organization subject to this article shall designate an office within this state for receipt of Complaints and Requests for Action. An insurer or rating organization may designate more than one office to receive Complaints and Requests for Action.

(b) Every insurer and rating organization subject to this article shall provide the address, telephone and facsimile number of a designated office to employers, insurers, insureds, insurance agents and brokers, or other persons inquiring about or making complaints regarding the actions of the insurer or rating organization. A rating organization shall also provide such persons with the telephone number and address of its policyholder ombudsman.

(c) Every insurer subject to this article and any insurance agent or broker through which an employer's insurance was transacted, shall provide the address, telephone and facsimile number of a designated office to employers in the notice required by subdivision (b) of Insurance Code section 11753.1 when the insurer adopts a change in classification that results in an increased premium. The notice required by subdivision (b) of Insurance Code section 11753.1 shall inform the employer of the right to request reconsideration of the classification assignment, and the right to appeal a decision rejecting reconsideration to the Commissioner pursuant to Insurance Code section 11753.1 and these regulations.

(d) Every insurer subject to this article shall include a notice which includes the information set forth in section 2509.77 with each policy of insurance issued or renewed beginning May 23, 1999.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c) and (h), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.44. Acknowledgment of Receipt and Notice of Review.

(a) Within thirty (30) days after service of a Complaint and Request for Action, the insurer or rating organization shall serve the applicant with a written acknowledgment of receipt of the Complaint and Request for Action and a notice either granting or denying review of the Complaint and Request for Action. If the insurer or rating organization fails to grant or reject review of the Complaint and Request for Action within thirty (30) days after the request is served, the applicant may proceed in the same manner as if the Complaint and Request for Action had been rejected. Time limitations for an appeal to the Commissioner shall not begin to run until this acknowledgment and notice has been served, unless a decision has been served pursuant to Section 2509.45, below. The acknowledgment shall include the information specified in Section 2509.45(d) and include the following statements:

(1) The insurer or rating organization's failure to grant or reject review of the Complaint and Request for Action within thirty (30) days of service of such Complaint and Request for Action constitutes a rejection of the Complaint and Request for Action.

(2) The insurer or rating organization's failure to grant or reject the Complaint and Request for Action within sixty (60) days after the insurer or rating organization has served the applicant with a notice granting the request for review constitutes a rejection of the Complaint and Request for Action.

(3) An appeal may be taken to the Commissioner from:

(A) a written rejection of review of the Complaint and Request for Action;

(B) a written rejection of the Complaint and Request for Action;

(C) failure of an insurer or rating organization to grant or reject a review of a Complaint and Request for Action or failure to grant or reject a Complaint and Request for Action within the time specified.

(4) Time limitations for an appeal to the Commissioner do not begin to run until this acknowledgment and notice have been served on the applicant, unless a decision on the Complaint and Request for Action has been served on the applicant, in which case an appeal to the commissioner must be filed within 30 days of service of the decision. If an acknowledgment and notice have been served, but no decision has been served within the time limits specified, an appeal may be taken to the Commissioner within 120 days after service of the Complaint and Request for Action on the insurer or rating organization.

(b) Where the acknowledgement concerns a Request for Policyholder Information, the acknowledgment shall also indicate that if the request is rejected in whole or in part, the rating organization is required to provide reasons for any rejection in writing and that an appeal may be taken to the Commissioner from a complete or partial written rejection of the request pursuant to Insurance Code section 11753.1. The rating organization shall serve a copy of a Complaint and Request for Action which concerns a Request for Policyholder Information, and a copy of the acknowledgment of receipt, upon insurers to which the request for policyholder information pertains. The service of these documents satisfies the duty to notify insurers imposed upon rating organizations by subdivision (a) of Insurance Code section 11752.6.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by

2–16–2000 or emergency language will be repealed by operation of law on the following day.

4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.45. Decision on Complaint and Request for Action; Time for Reconsideration; Notice of Appeal Rights.

(a) Within sixty (60) days after the insurer or rating organization serves the applicant with a notice granting review of the Complaint and Request for Action, the insurer or rating organization shall serve the applicant with a written decision upon the Complaint and Request for Action. The decision shall provide the insurer's or rating organization's evaluation of the Complaint and Request for Action and contain a recitation of the pertinent facts and a determination of the issues presented which grants or rejects in whole or in part the Complaint and Request for Action. The decision shall include a specific statement of the basis for the action taken. If an acknowledgment and notice have not been served pursuant to Section 2509.44, above, the decision shall include the statements required in the acknowledgment and notice. If the insurer or rating organization fails to grant or reject the Complaint and Request for Action within sixty (60) days after the notice granting review was served, the applicant may proceed in the same manner as if the Complaint and Request for Action had been rejected.

(b) An employer, insurer, or other aggrieved person may request reconsideration of a decision of an insurer or the designated rating organization served pursuant to subsection (a) of this section. The request for reconsideration shall be in writing and shall be served within thirty (30) days of service of the decision. The insurer or rating organization shall serve a decision on reconsideration within thirty (30) days of service of the request for reconsideration.

(c) A decision which grants a Request for Policyholder Information, or rejects the request in part, shall be accompanied by such portions of the policyholder information requested that the rating organization has agreed to make available and for which payment has been received.

(d) If review of the Complaint and Request for Action is rejected or the Complaint and Request for Action is rejected, the decision shall include a statement in substantially the following form, in bold:

You have only 30 days from the date this decision was served on you to appeal the decision to the California Insurance Commissioner. See Title 10, California Code of Regulations, section 2509.46.

Address your appeal to:

ADMINISTRATIVE HEARING BUREAU
DEPARTMENT OF INSURANCE
45 FREMONT STREET, 22ND FLOOR
SAN FRANCISCO, CA 94105
(415) 538–4102

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending subsection (d) and amending NOTE filed 1–2–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 1).
7. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.46. Appeals to the Insurance Commissioner; Time Frame for Filing Written Appeal.

An appeal to the Insurance Commissioner from a written decision of an insurer or rating organization shall be filed within thirty (30) days after service of rejection of review of the Complaint and Request for Action or service of rejection of the Complaint or Request for Action. If an insurer or rating organization fails to serve a written decision, the appeal shall be filed within one hundred and twenty (120) days after service of the Complaint and Request for Action upon the insurer or rating organization. If a request for reconsideration was made pursuant to section 2509.45(b), an appeal shall be filed within thirty (30) days after service of the decision on reconsideration, or if the insurer or designated rating organization fails to serve a written decision on reconsideration, the appeal shall be filed within sixty (60) business days after service of the request for reconsideration. The time to appeal shall not exceed one year after the Complaint and Request for Action was served on the insurer or rating organization. However, the hearing officer may grant further time for the filing of an appeal if he or she determines that the delay was caused by the excusable neglect of the appellant or other circumstances beyond the reasonable control of the appellant.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.47. Form of Appeal and Information Required.

An appeal shall be in writing. It need not be in any particular form, but must include:

(a) The name, address, telephone number, and fax number of the appellant;

(b) The name, address, telephone number, and fax number of the appellant's representative, if any;

(c) Copies of correspondence between the appellant and the insurer and/or rating organization regarding the subject of the appeal, to include: complaints, responses, inquiries, initial decisions, requests for review and action, requests for reconsideration, requests for policyholder information, acknowledgements, notices, and the written decisions of insurers and rating organizations;

(d) A statement as to why the appellant believes the insurer's or rating organization's decision or action is wrong;

(e) Any documents which support the appellant's position, which are reasonably available to the appellant at the time of the filing of the appeal, and upon which the appellant intends to rely at the hearing. The documents should be marked consecutively by letter as provided in section 2509.62(c).

(f) A statement that the appellant has or has not filed a complaint with the Department requesting review of the same transactions, actions or omissions which constitute the subject matter of the appeal. If such a

complaint has been previously filed or is pending, the appellant shall provide the Department's assigned file number.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.48. Filing Requirements.

An original and one copy of the appeal must be filed with the Commissioner.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.49. Service of Copy of the Appeal.

The appellant shall serve a copy of the appeal on the office designated by each respondent named in the appeal for receipt of Complaints and Requests for Action, at the same time the appeal is filed with the Commissioner. All served documents shall be accompanied by a copy of a declaration of service. Service by first class mail, registered mail or mail delivery service is complete at the time of deposit with the carrier, but any prescribed period of notice and any right of duty to do any act or make any response within any prescribed period or on a date certain after mail service of the document served shall be extended for a period of five days.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.50. Role of Department of Insurance.

The Department of Insurance is not a party to an appeal unless the agency specifically requests to participate in the proceedings. All such requests shall be granted.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.51. Designated Rating Organization.

Whenever an appeal concerns the application of the classification system, uniform experience rating plan, uniform statistical plan or miscellaneous regulations for the recording or reporting of data developed by the designated rating organization, the Commissioner shall transmit a copy of the appeal to the designated rating organization. If the designated rating organization is not otherwise a respondent in the proceeding, the designated rating organization may participate in the proceeding.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.52. Representation.

An appellant may, but need not, be represented in the proceedings before the Commissioner. A representative need not be an attorney.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.

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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.53. Pre–Hearing Procedural Provisions; Acknowledgment of Appeal; Assignment of Hearing Officer; Stay of Proceedings; Alternative Dispute Resolution.

(a) The Commissioner shall acknowledge the receipt of an appeal and shall provide the appellant instructions concerning information that must be submitted to the Department.

(b) An appeal shall be considered submitted when sufficient information is received by the Commissioner from the appellant to establish the nature of the complaint and the relief requested and when the appeal has been properly served on all the parties.

(c) Upon submission of an appeal, the Commissioner shall direct the appeal to a hearing officer. The hearing officer shall notify the parties in writing of his or her assignment.

(d) If all parties agree, the hearing officer may refer an appeal for resolution to a neutral mediator for mediation or to a neutral arbitrator for arbitration pursuant to the procedures set forth in Government Code Section 11420.10.

(e) The Commissioner may deny an appeal without a hearing if he or she has information on the subject from which the appeal is taken and he or she believes that a reasonable basis for the appeal does not exist or that the appeal is not made in good faith. The denial shall be in writing and shall set forth the basis for the denial and shall be served on all parties.

NOTE: Authority cited: Sections 11400.20 and 11420.10, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.54. Insurer or Rating Organization Response to Appeal.

(a) The insurer or rating organization shall file and serve its response to the appeal within 14 days from the service of the appeal unless the hearing officer grants the insurer or rating organization more time pursuant to a showing of good cause. If the rating organization has joined as a party to the appeal pursuant to Section 2509.51, the rating organization shall file and serve its response within 14 days of service of notice that it has been made a party. The hearing officer may give the rating organization more time pursuant to a showing of good cause. The response shall admit or deny each material allegation in the appeal and raise any defenses or justifications. It shall also set forth any defects in the appeal.

(b) The response must include:

(1) Copies of any correspondence exchanged between the parties concerning the subject matter of the appeal, that were not filed with the appeal;

(2) Copies of any documents in the rating organization's file or the insurer's policyholder file that are relevant to the subject matter of the appeal, that were not filed with the appeal; and

(3) Copies of all statutory, regulatory, or manual provisions the rating organization or insurer relied on in taking its action.

(c) An original and two copies of the insurer's or rating organization's response shall be filed with the Hearing Officer. A copy of the response shall be served on all other parties to the appeal at the same time it is filed with the hearing officer.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.55. Objections to Insurer or Rating Organization's Response.

The appellant shall have 15 days from the date of service of the response to file and serve any reply to the insurer's or rating organization's response to the appeal.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.56. The Hearing—When Held.

The Commissioner shall hold a hearing within 60 days of receipt of a completed appeal, provided however that a hearing may be held later upon agreement of the parties to the appeal. The Commissioner shall give to the parties not less than 10 days written notice of a hearing.

NOTE: Authority cited: Sections 11753.1 and 11737(f), Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99

or emergency language will be repealed by operation of law on the following day.

2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.57. The Hearing—Governing Procedure and Location.

Hearings on appeals shall be conducted pursuant to the procedural provisions of these regulations and those provisions of Chapter 4.5 of Title 2, Division 3, Part 1 of the Government Code, commencing with section 11400 which are mandatory for these regulations, and those optional provisions of Chapter 4.5 specifically adopted herein. The provisions of Chapter 5 (commencing with Government Code section 11500) are not applicable to these proceedings. Hearings shall be conducted in either Los Angeles or San Francisco.

(a) The hearing officer may conduct a hearing using informal hearing procedures.

(b) The hearing officer may deny use of the informal hearing procedure, or may convert an informal hearing to a formal hearing after an informal hearing is commenced.

NOTE: Authority cited: Sections 11400.20, 11445.20 and 11445.50, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.58. Hearing Officer—Authority.

(a) The hearing officer shall exercise all powers relating to the conduct of the hearing.

(b) The hearing officer may conduct all or part of the proceeding by telephone, television, or other electronic means if each participant in the hearing has an opportunity to participate in and to hear the entire proceeding while it is taking place and to observe exhibits, which shall have been previously received by all parties and by the hearing officer.

(c) The hearing officer shall control the course of the proceedings; rule upon requests for continuances; administer oaths; issue subpoenas; rule on the various motions and objections of the parties; receive evidence, including additional documents; upon notice, hold appropriate conferences before or during hearings; receive offers of proof; hear argument; approve or reject proposed stipulations; and, fix the time and place for the filing of written comment or briefs.

(d) The hearing officer may limit the use of witnesses, testimony, evidence, argument, pleadings, and intervention. However, the parties must be given a reasonable opportunity to be heard, including the opportunity to present and rebut evidence.

(e) The hearing officer shall take any other action necessary or appropriate to the discharge of his or her duties, consistent with the statutory or other authority under which the Commissioner functions. The hearing officer may issue such orders compelling the compliance of the parties and other persons subject to the jurisdiction of the Commissioner as are necessary to the discharge of his or her official duties. Article 12 of Chapter 4.5 of the Administrative Procedure Act (commencing with Government Code section 11455.10), is adopted, and is applicable to these proceedings.

(f) The Commissioner shall exercise all authority set forth in this section until a proceeding is assigned to a hearing officer.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(f), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.59. Discovery.

Formal discovery by the parties will be permitted by the hearing officer only upon written notice and a showing of good cause.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.60. Subpoenas.

Pursuant to Insurance Code section 12924, subpoenas and subpoenas duces tecum may be issued at the discretion of the hearing officer for the attendance of witnesses and production of documents at the hearing. Any party requesting the issuance of a subpoena must submit a written subpoena request to the hearing officer. The provisions of Article 11 of Chapter 4.5 (commencing with section 11450.05 of the Government Code) are not applicable to these proceedings.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.61. Burden of Proof.

(a) A party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he or she is asserting.

(b) A party claiming that a party has engaged in subterfuge or fraud, or asserting an affirmative defense, has the burden of proof on that issue.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 500, Evidence Code; Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.62. Evidence.

(a) Oral evidence, if taken, shall be taken only on oath or affirmation.

(b) Each party shall have these rights: to present evidence, to argue a case to the hearing officer and to rebut the evidence against the party.

(c) Documentary exhibits shall be legible and reduced to 8–1/2 inches wide and 11 inches long and shall be marked for identification consecutively as follows: appellant's exhibits by letter; respondent's exhibits by number. The moving party shall furnish the original and one copy to the hearing officer, one copy to each party or its representative of record, and one copy for use by a witness, if appropriate. Each page of multi–page exhibits shall be numbered. Copies of exhibits shall be clear and legible. Exhibits introduced at the hearing shall not duplicate the documents filed with the appeal or the response. The parties shall exchange their exhibits with each other five (5) business days prior to the hearing.

(d) The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of evidence over objection in civil actions.

(e) The rules of privilege shall be effective to the extent that they are otherwise required by law to be recognized at the hearing.

(f) The hearing officer has the discretion to exclude evidence if its probative value is substantially outweighed by the probability that its admission will necessitate undue consumption of time.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

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6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.63. Order of Proof.

In the absence of a contrary order by the hearing officer, the appellant shall present its evidence first.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

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6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.64. Hearing Reporter.

The proceedings at the hearing shall be reported by a hearing reporter. However, upon the consent of all the parties, the proceedings may be reported electronically. Parties must make their own arrangements with the reporter if they wish to obtain a copy of the reporter's transcript.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

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§ 2509.65. Continuances; Good Cause.

(a) A continuance for any act occurring under this article may be granted by the Commissioner or the hearing officer for good cause shown.

(b) When seeking a continuance, a party shall apply for the continuance within ten (10) business days following the time the party discovered or reasonably should have discovered the event or occurrence which establishes the good cause for the continuance. A continuance may be granted for good cause after the ten (10) business days have lapsed if the party seeking the continuance is not responsible for or has made a good faith effort to prevent the condition or event establishing the good cause.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

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5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.66. Additional Evidence or Briefing.

(a) At the hearing, the hearing officer may require the production of further evidence or briefing on any issue. If the hearing officer determines that specific evidence or briefing is necessary as a part of the record, the hearing officer shall set a deadline for filing of the requested evidence or briefing.

(b) Unless ordered by the hearing officer, or upon written motion for good cause shown, no additional evidence shall be introduced after the close of the evidentiary hearing.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.67. Official Notice.

In reaching a decision, official notice may be taken, either before or after submission of the case for decision, of any fact which may be judicially noticed by the courts of this state. The parties shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto. Each party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing officer.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.68. Proposal of Stipulations or Settlements.

(a) Parties may stipulate to the resolution of an issue of fact or the applicability of a provision of law material to a proceeding, or may agree to settlement on a mutually acceptable outcome to a proceeding, with or without resolving material issues.

(b) Stipulations shall be filed with the hearing officer, or the Commissioner if a hearing officer has not been designated, for acceptance or rejection.

(c) No evidence of an offer of compromise or settlement made in settlement negotiations is admissible in a hearing, whether as affirmative evidence, by way of impeachment, or for any other purpose.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.69. The Insurance Commissioner's Decision.

(a) Within 60 days after the case is submitted for decision, the hearing officer shall prepare and deliver to the Commissioner a proposed decision in a form that may be adopted as the decision in the case. Failure of the hearing officer to deliver a proposed decision within the time required does not prejudice the rights of the Department in the case.

(b) The Commissioner shall issue his or her decision within 60 days of receipt of the proposed decision.

(c) The Commissioner may adopt the proposed decision in its entirety or he may make technical or other minor changes in the proposed decision and adopt it as the decision. Action by the Commissioner under this subsection is limited to a clarifying change or a change of a similar nature that does not affect the factual or legal basis of the proposed decision.

(d) If the proposed decision is not adopted as provided in subsection (c), the Commissioner may decide the case upon the record, including the transcript, or an agreed statement of the parties, with or without taking additional evidence, or may refer the case to the same hearing officer if reasonably available, otherwise to another hearing officer, to take additional evidence. Upon request, a copy of the record shall be made available to the parties, at their cost.

(e) If the case is assigned to a hearing officer, he or she shall prepare a proposed decision as provided in subsection (a) upon the additional evi-

dence and the transcript and other papers which are part of the record of the prior hearing.

(f) The Commissioner shall decide no case provided for in subsection (e) without affording the parties the opportunity to present either oral or written argument before the Commissioner.

(g) The proposed decision shall be deemed adopted by the Commissioner 60 days after delivery by the hearing officer, unless within that time

(1) the Commissioner notifies the parties that the proposed decision is not adopted as provided in subsection (d) and commences proceedings to decide the case upon the record, including the transcript, or

(2) the Commissioner refers the case to the hearing officer to take additional evidence.

(h) If the Commissioner finds that a further delay is required by special circumstances, he or she shall issue an order delaying the decision for no more than 30 days and specifying the reasons therefor.

(i) The final decision of the Commissioner, or the proposed decision that was deemed adopted pursuant to subsection (g) above, shall be a public record and a copy shall be served on each party and his or her representative of record by registered or certified mail.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.70. Appeals for Correction of Mistake or Clerical Error.

(a) Within fifteen (15) days after service of a copy of the decision on a party, but not later than the effective date of the decision, the party may apply to the Commissioner for correction of a mistake or clerical error in the decision, stating the specific ground on which the application is made. Notice of the application shall be given to the other parties to the proceeding. The application is not a prerequisite for seeking judicial review.

(b) The Commissioner may refer the application to the hearing officer who formulated the proposed decision or may delegate his or her authority under this section to one or more persons.

(c) The Commissioner may deny the application, grant the application and modify the decision, or grant the application and set the matter for further proceedings. The application is considered denied if the Commissioner does not dispose of it within fifteen (15) days after it is served on the Commissioner and the other parties.

(d) Nothing in this section precludes the Commissioner, on his or her own motion or on motion of the hearing officer, from modifying the decision to correct a mistake or clerical error. A modification under this subsection shall be made within 30 days after issuance of the decision.

(e) The hearing officer or the Commissioner shall, within fifteen 15 days after correction of a mistake or clerical error in the decision, serve a copy of the correction on each party on which a copy of the decision was previously served.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.71. Effective Date of Decision.

The decision shall become effective 30 days after it is delivered or mailed to the parties unless a reconsideration is ordered within that time, or the Commissioner orders that the decision shall become effective sooner.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.72. Reconsideration.

The Commissioner may order a reconsideration of all or part of the case on his or her own motion or on petition of any party. Petitions for reconsideration must be served on all parties. The power to order a reconsideration shall expire 30 days after service of a decision on the parties, or on the date set by the Commissioner as the effective date of the decision if that date occurs prior to the expiration of the 30–day period or at the termination of a stay of not to exceed 30 days which the Commissioner may grant for the purpose of filing an application for reconsideration.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).

5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.73. Contents of Petition.

Petitions for reconsideration shall be based solely upon, and shall set forth specifically, the grounds upon which the decision of the Commissioner allegedly is contrary to law or is erroneous. A petition for reconsideration shall not refer to, or introduce, any evidence which was not part of the record of the evidentiary hearing. Any such evidence nonetheless provided shall be accorded no weight. Copies of documents received in evidence or already part of the record shall be referenced and attached as exhibits.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.74. Response.

A response of other parties to a petition for reconsideration is not required. However, if a response is provided, it must be filed and served within fifteen (15) days of service of the petition for reconsideration.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.75. Hearing on Petition.

The Commissioner may, but is not required to hold a hearing or accept argument on the petition for reconsideration.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.76. Judicial Review.

Judicial review of the Commissioner's final decision may be had by filing a petition for a writ of mandate in accordance with the provisions of section 1094.5 of the Code of Civil Procedure. The right to petition shall not be affected by the failure to seek reconsideration before the Commissioner.

(a) Except as otherwise provided in this section the petition shall be filed within ninety (90) days after the last day on which reconsideration can be ordered.

(b) On request of the petitioner for a record of the proceedings, the complete record of the proceedings, or the parts thereof as are designated by the petitioner in the request, shall be prepared by the Department and shall be delivered to petitioner, within 30 days after the request. The time shall be extended for good cause shown. The petitioner shall pay the fee for the transcript and the cost of preparation of the other portions of the record. The hearing officer shall determine the cost of preparation of other portions of the record.

(c) The complete record includes the pleadings, all notices and orders issued by the Department, any proposed decision by a hearing officer, the final decision, a transcript of all proceedings, the exhibits admitted or rejected, the written evidence and any other papers in the case.

(d) Where petitioner, within 10 days after the last day on which reconsideration can be ordered, requests the Commissioner or Hearing Officer to prepare all or any part of the record the time within which a petition may be filed shall be extended until 30 days after delivery of the record.

(e) The Commissioner may file with the court the original of any document in the record in lieu of a copy thereof.

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.77. Forms—Notice of Policyholder Appeal Rights.

The Notice required by subsection 2509.43(d) shall include:

1. Notice of the right to receive policyholder information from the rating organization pursuant to Insurance Code section 11752.6 (Include name, address, phone and fax number.)

2. Notice of the right to contact the rating organization's policyholder ombudsman pursuant to Insurance Code section 11752.6(g) and (h)(1). (Include name, address, phone and fax number.) (The Notice should also include the language required by subdivisions (h)(2) and (h)(3) of section 11752.6)

3. Notice of the right to dispute the actions of the insurer or rating organization pursuant to Insurance Code sections 11737(f) and 11753.1. (In-

clude name, address, phone and fax numbers for office designated for receipt of complaints for both insurer and rating organization.)

4. Notice of the right to appeal to the Insurance Commissioner from the actions of the insurer or rating organization pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1 and these regulations.

5. Notice of the right to a hearing before the Insurance Commissioner

6. The filing address for all appeals to the Commissioner is:

ADMINISTRATIVE HEARING BUREAU
CALIFORNIA DEPARTMENT OF INSURANCE
45 FREMONT STREET, 22ND FLOOR
SAN FRANCISCO, CA 94105

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c) and (h), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 6–18–99 as an emergency; operative 6–18–99 (Register 99, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–99 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 10–18–99 as an emergency; operative 10–19–99 (Register 99, No. 43). A Certificate of Compliance must be transmitted to OAL by 2–16–2000 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending section and NOTE filed 1–2–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 1).
7. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2509.78. Forms—Declaration of Service by Mail.

The following form may be used by a party when serving other parties.

DECLARATION OF SERVICE BY MAIL

In the Matter of

_____
Appellant
vs.

_____
Respondent
(Insurer or Rating Organization)

I am over the age of 18 years and not a party to this case. On the ____ day of _____, in the year _____, at _____ (city), _____ (state), I sealed into an envelope and deposited in the United States mail, postage thereon fully prepaid, true copies of the following documents in the above–entitled matter. The original or a true copy of each document served is attached hereto. Said copies were addressed as follows:

_____Certified/Registered Mail
Number (if applicable)

I declare under penalty of perjury that the foregoing is true and correct. Executed on _____ (month, day), _____ (year) at _____ (city), _____ (state).

_____
(print name)
Declarant

NOTE: Authority cited: Section 11400.20, Government Code; and Section 11753.1, Insurance Code. Reference: Section 11415.10, Government Code; and Sections 11734, 11737(f), 11750, 11752.6(c) and (h), 11753.1(a) and 11753.1(b), Insurance Code.

HISTORY

1. New section filed 2–22–99 as an emergency; operative 2–22–99 (Register 99, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–18–99 or emergency language will be repealed by operation of law on the following day.
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4. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 6).
5. New section filed 2–10–2000; operative 3–11–2000 (Register 2000, No. 6).
6. Change without regulatory effect amending NOTE filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

Article 10. Mortgage Guaranty Insurers

§ 2510. Purpose and Authority.

The rules and regulations set forth in this article are necessary to carry out the provisions of Chapter 2A, Part 6, Division 2 of the Insurance Code.

NOTE: Authority cited for Article 10: Sections 12640.04, 12640.16 and 12640.18, Insurance Code.

HISTORY

1. New article 10 (Sections 2510 through 2521) filed 6–14–62; designated effective July 15, 1962 (Register 62, No. 12).

§ 2510.1. Financial Statements.

The financial statements required by Section 12640.16(a) of the Insurance Code and quarterly statements with complete schedules shall be furnished on the form of financial statements prescribed for use by fire and casualty insurers; except that the unearned premium reserves, the contingency reserves, and the loss reserves required by Sections 12640.16(b), 12640.04 and 12640.16(c), respectively, of the Insurance Code shall be shown in accordance with the provisions of said sections of the Insurance Code and Sections 2513, 2514 and 2515 hereof.

HISTORY

1. Renumbering of Section 2511 to 2510.1 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.2. Same; Reporting of Expenses.

Expenses shall be recorded and reported in accordance with the "Uniform Classification of Expenses of Fire and Marine Casualty and Surety Insurers" as required in said annual statement.

HISTORY

1. Renumbering of Section 2512 to Section 2510.2 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.3. Computation of Unearned Premium Reserve.

Mortgage Guaranty insurers shall compute the unearned premium reserve on a monthly pro rata basis, except in the case of premiums paid in advance for four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, or fifteen–year policies the annual unearned premium factors specified below shall apply (or comparable factors to be applied monthly consistent with the schedule below on the basis that one–twelfth of the earned premium for each contract year is earned during each month therein):

Contract Year Current at Valuation Date	Unearned Premium Factor at Valuation Date*											
	4 year Policy	5 year Policy	6 year Policy	7 year Policy	8 year Policy	9 year Policy	10 year Policy	11 year Policy	12 year Policy	13 year Policy	14 year Policy	15 year Policy
1	95.7%	96.5%	97.0%	97.3%	97.5%	97.7%	97.7%	97.8%	97.8%	97.8%	97.8%	97.8%
2	76.4	81.0	83.7	85.4	86.5	87.3	87.6	87.9	88.1	88.1	88.2	88.2
3	45.2	56.0	62.2	66.2	68.8	70.4	71.3	71.9	72.3	72.5	72.6	72.6
4	14.5	31.3	41.1	47.4	51.3	53.8	55.3	56.1	56.7	57.1	57.2	57.3
5		9.9	22.7	31.0	36.2	39.4	41.3	42.5	43.2	43.7	43.9	44.0
6			7.1	17.1	23.3	27.2	29.5	30.9	31.8	32.3	32.7	32.8
7				5.4	12.5	16.9	19.6	21.2	22.1	22.8	23.2	23.3
8					3.8	8.6	11.6	13.3	14.4	15.1	15.5	15.7
9						2.5	5.6	7.5	8.6	9.3	9.9	10.1
10							1.6	3.4	4.6	5.4	6.0	6.2
11								0.9	2.1	2.9	3.5	3.7
12									0.6	1.3	1.9	2.1
13										0.4	0.9	1.1
14											0.3	0.5
15												0.1

*Includes 50% of the earned premium applicable to the contract year current at valuation date. This is necessary if it is assumed the average policy is written in the middle of the contract year and these factors are applied annually to groups of policies segregated by policy term and expiration year.

Whenever the laws of any other jurisdiction in which a mortgage guaranty insurer subject to the requirements of this section is also licensed to transact mortgage guaranty insurance require a larger unearned premium reserve in the aggregate than that set forth herein, the establishment of such larger unearned premium reserve shall be deemed to be compliance with this section.

HISTORY

1. Amendment filed 10–25–74; designated effective 1–1–75 (Register 74, No. 43).
2. Renumbering of Section 2513 to Section 2510.3 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.4. Reporting of Contingency Reserve.

The contingency reserve established and maintained as required by Section 12640.04 of the Insurance Code shall be reported in the annual statement as a liability, but this requirement shall not affect the computation of the amount of mortgage guaranty insurance which may be written in accordance with the provisions of Sections 12640.05 or 12640.08 of the Insurance Code.

HISTORY

1. Renumbering of Section 2514 to Section 2510.4 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.5. Determination of Actual Loss; Valuation of Loss Reserves.

The actual loss of the mortgage guaranty insurer on any claim shall be determined as of the time of the settlement of the loss with the insured. In setting up the loss reserves on the case basis as required by Section 12640.16(c), any estimate of loss expected to be paid on any claim, or ultimately to be suffered on any claim settled by acquisition of title to the encumbered real estate or the authorized real estate security (as the term is defined in Section 12640.02(b) of the Insurance Code) shall be the maximum liability of the insurer under its policy of mortgage guaranty insurance until a different estimate of any such loss is supported by an appraisal by a qualified real estate appraiser of the real estate so acquired or which secures the authorized real estate security. No real property or authorized real estate security may be valued at an amount greater than that permitted for the valuation thereof by fire and casualty insurers.

HISTORY

1. Renumbering of Section 2515 to Section 2510.5 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.6. Withdrawal from Contingency Reserve.

Withdrawals shall be made from the contingency reserve required to be maintained under Insurance Code Section 12640.04 of that portion of

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such reserve which has been established more than 120 months prior to the date of any such withdrawal, and shall no longer constitute any part of the contingency reserve.

HISTORY

1. Amendment filed 5–28–74 as procedural and organizational; effective upon filing (Register 74, No. 22).
2. Renumbering of Section 2516 to Section 2510.6 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.7. Use of Contingency Reserves for Loss Payments.

Subject to the written consent of the Insurance Commissioner or supervisory official of the jurisdiction in which a mortgage guaranty insurer is domiciled, the contingency reserve shall be available for loss payments only when and to the extent that the incurred losses in any calendar year exceed expected losses for such year. The term "expected losses" as used herein and in Section 12640.04 of the Insurance Code is defined to mean an amount equal to 20 percent of the premium earned during such calendar year without diminution because of contributions to the contingency reserve.

HISTORY

1. Renumbering of Section 2517 to Section 2510.7 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.8. Same; Accounting Basis.

Release of moneys from the contingency reserve for payment of losses in accordance with Section 2517 shall be on the first–in–first–out basis.

HISTORY

1. Renumbering of Section 2518 to Section 2510.8 filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.9. Policy Form Requirements.

Mortgage guaranty insurance policy forms, defined in Section 12640.02(a) of the California Insurance Code and issued for delivery in this State, shall contain the following:

(a) An insuring clause;

(b) A schedule specifying the effective date of coverage, the policy period, and the insurance premium applied;

(c) Renewal provision;

(d) Definitions;

(e) Conditions precedent to filing a claim, if applicable, including but not necessarily limited to:

(1) The presence of adequate hazard insurance covering damage to the property at the time of loss;

(2) Payment of all taxes;

(3) Payment of all sales expenses;

(4) Payment of all foreclosure costs;

(f) A condition precedent to payment in the event of default providing the insured must restore the property to its condition at the time of issuance of the policy, reasonable wear and tear being expected;

(g) A condition describing in full detail the loss provisions and recoveries to be received by the insured or its beneficiary on both settlement options applicable to the insurer as provided for under Section 12640.09 (a) of the California Insurance Code;

(h) A provision that the insurer has the option to pay the loss limits or acquire title. If a claim is submitted for settlement, the option may be elected and exercised only by the insurer who shall use its best judgement in determining the method of settlement that will minimize its loss;

(i) A filing of claims provision which shall set forth the place of filing and reporting, and to whom it is applicable;

(j) The legal rights agreement, if any;

(k) A waiver of conditions provision, if applicable;

(*l*) A conflict of laws provision providing for conformity with California law;

(m) In addition to the other policy form requirements set forth in this Section, a pool insurance policy shall be subject to the following:

(1) The aggregate loss limits provision contained in a policy covering a pool of mortgages shall not be made subject to adjustment, either directly or indirectly, to reflect the profit or excess of net proceeds received by the insurer from the sale of the property over and above the actual loss of the lender, when the insurer has elected to acquire the property in settlement of a claim, and the insurer shall not be permitted, directly or indirectly, to credit or refund any such excess or profit to the insured or any other party to the pooled insurance arrangement, and

(2) It must contain a provision setting forth the insurer's conditions established pursuant to Section 2510.18 of this Article, as well as the procedures under which the final premium will be charged against the equivalent amount available under the aggregate loss limit set forth in the pool insurance policy, or any other method agreeable to the insurer and the insured which satisfies the requirements of Section 2510.18 of this Article.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.10. Specific Requirements Applicable to Pool Insurance Policies.

In addition to the other requirements of this Article, Sections 2510.11 through 2510.22 are added and made applicable exclusively to mortgage guaranty insurers engaged in writing or reinsuring mortgage guaranty insurance pursuant to pool insurance policies.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.11. Definition of Pool Insurance Policy.

A pool insurance policy is a policy of mortgage guaranty insurance which insures the individual loans in a pool of mortgage loans that are secured by real property in California and that collarteralize a mortgage-backed security and which covers the losses on individual loans, subject to an aggregate loss limit, for the benefit of the insured or its named beneficiary.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.12. Limitation on Exposure.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).
2. Repealer filed 9–5–85; effective thirtieth day thereafter (Register 85, No. 36).

§ 2510.13. Substitution of Mortgage Loans.

Any pool mortgage loans insured must be on a "closed end" basis and no substitution of mortgage loans will be allowed; provided, however, if a loan in the pool is paid in full by the borrower, within thirty (30) days after inception of the insurance policy another loan may be substituted to replace the original loan; the substituted mortgage loan must be made subject to underwriting and review by the mortgage guaranty insurer and be found acceptable to the insurer prior to being added to the pool.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.14. Assumption or Substitution of Borrowers.

Assumption without the release of the original borrower is permitted. Any assumption that leads to the release of the original borrower and substitution of a new borrower shall be considered a termination of the insurance coverage extended under the pool insurance policy as to that particular loan unless all of the following conditions are met:

(a) At the time of substitution, the loan is for no greater than the amount of outstanding balance on the original loan insured;

(b) It is limited to the same property as originally insured;

(c) The interest rate is the same as the interest rate on the original loan if fixed, or if it is a variable interest rate, it does not exceed the maximum interest rate allowable under law on the original mortgage loan insured;

(d) The criteria applied in the underwriting and credit evaluation of the substituted borrower is not less favorable to the insurer than that criteria applied to the original borrower;

(e) The substitution is made subject to the prior approval of the mortgage guaranty insurer;

(f) The existing coverage is not, in whole or in part, changed or affected as to the individual insured mortgage loan to be substituted or as to the overall pool insurance policy, and

(g) No substitution mortgage loan in any one pool shall remain covered under the pool insurance policy if its remaining principal balance at the time the substitution occurs, when added to the then current remaining principal balances of all previously substituted mortgage loans, exceeds the unexhausted and available aggregate ceiling of loss under the same pool insurance policy at the time of such calculation.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.15. Minimum Requirements.

NOTE: Authority cited: Section 12640.18, Insurance Code. Reference: Sections 12640.01–12640.19, Insurance Code.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).
2. Repealer of subsection (d) and consecutive relettering of subsection (e) filed 11–21–80 as an emergency; effective upon filing (Register 80, No. 47). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3–21–81.
3. Certificate of Compliance transmitted to OAL 3–20–81 and filed 4–17–81 (Register 81, No. 16).
4. Repealer filed 11–13–81; effective thirtieth day thereafter (Register 81, No. 46).

§ 2510.16. Liability Limitations.

The total liability of mortgage guaranty insurer under a pool insurance policy shall be limited as follows:

(a) To the maximum aggregate ceiling of loss;

(b) If a mortgage guaranty insurer agrees to write in excess of twenty-five percent (25%) at risk of the entire indebtedness on individual mortgage loans, through utilization of reinsurance, as provided for in Section 12640.09(c) of the California Insurance Code, the total net liability of such insurer under the pool insurance policy, both directly and indirectly, shall be limited to the actual amount of loss to the insured on each individual loan insured;

(c) The determination of the actual amount of loss to the insured shall not be subject to any adjustment resulting in any credit due to deductions, netting, or otherwise, upon resale of the property in the event that the mortgage guaranty insurer exercises its option during the claims period to acquire the property to mitigate its losses, other than that which is described under Section 2510.9(m)(1) of this Article, and

(d) The maximum liability of the insurer will be reached when the cumulative actual amount of loss to the insured equals the initial aggregate loss limit under the pool insurance policy.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.17. Assignments of Title to Mortgage Properties.

Upon claim and foreclosure all titles to the mortgaged properties insured must be freely assignable to the mortgage guaranty insurer without any conditions, restrictions or limitations, whether contractual or otherwise, being imposed by any party who is or might be involved in any capacity under the pool insurance policy or the pool loan arrangement.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.18. Premium.

A mortgage guaranty insurer is entitled to receive the full premium agreed upon under the pool insurance policy. Upon achieving the aggregate ceiling of loss under the policy, the insurance coverage terminates automatically. The mortgage guaranty insurer is then entitled to accelerate and call for the balance of the premium if the aggregate ceiling of loss is reached prior to the twelfth (12th) contract year of such insurance policy. Assuming that the premium for the policy has been prepaid for a twelve (12) year period, the premium is then adjusted by the premium actually paid under the policy. The resulting balance then must be reduced to the present value by applying a reasonable rate of interest. The following steps are used in the additional premium calculation:

(a) Average monthly premium collected to date multiplied by 144 months = Total expected premium for 12 year period.

(b) Multiply "total expected premium" from subsection (a) of this Section by the appropriate cumulative earned factor from the following table (as specified in the California Administrative Code, Title 10, Chapter 5, Subchapter 3, Article 10, Section 2513). The result will equal the total premium to be earned between inception and termination as follows:

Termination at End of Contract Year	*Cumulative Earned Factor*
1	.044
2	.195
3	.360
4	.506
5	.630
6	.735
7	.823
8	.890
9	.938
10	.970
11	.989
12	1.000

(Total premium earned between inception and termination) = (Total expected premium from subsection (a) of this Section) x (Cumulative earned factor)

If this step results in a negative figure, this subsection is to be disregarded.

(c) Initial additional premium = (Earned premium under subsection (b) of this Section less premium already paid)

(d) Additional premium due = (Total premium from mortgage guaranty insurer = subsection (c) of this Section) x $\frac{1}{(1+i)^n}$

whereby:
i = annual rate of interest.
n = years from termination to end of assumed 12 year period.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.19. Proration of Earned Premium Factor.

Pursuant to subsection (b) of Section 2510.18 of this Article, if termination of the pool insurance policy occurs during the year, the earned premium factor of the current year must be prorated and added to the cumulative earned premium factor of the prior year.

HISTORY

1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.20. Limitations on Assuming Mortgage Guaranty Insurers Under Reinsurance Contracts.

The assuming insurer to a reinsurance agreement under a pool insurance policy, as described in Section 12640.09(a) of the California Insurance Code, shall be subject to the same limitations and restrictions on its portion of retention or assumed insurance writings as the direct writer and shall retain only a maximum of twenty–five percent (25%) at risk of the entire indebtedness on individual mortgage loans and must reinsure the excess. No reinsurer shall retain more than twenty–five percent (25%) of the amount at risk on individual mortgage loans.

HISTORY
1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.21. Affiliated Mortgage Guaranty Insurers.

A ceding insurer shall not reinsure any pooled mortgage loans under a pool insurance policy with an affiliated company. A mortgage guaranty insurer shall not participate in any reinsurance contract under pooled mortgage loans, directly or indirectly, with an affiliated insurance company.

HISTORY
1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2510.22. Filing of Reinsurance Contracts, Prospectus and Private Placement Memorandum.

Within thirty (30) days after a pool insurance policy is issued, reinsurance contracts, final prospectus and private placement memorandum must be filed with the Insurance Commissioner for reporting purposes and the Commissioner may request such other information and documentation as he deems necessary and proper.

HISTORY
1. New section filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34).

§ 2519. Filing of Policy Forms.

HISTORY
1. Repealer filed 8–23–78; effective thirtieth day thereafter (Register 78, No. 34). For history of former section see Register 62, No. 12.

§ 2520. Licensing of Producers.

Any person engaging in the transaction of mortgage guaranty insurance with or on behalf of a mortgage guaranty insurer is subject to the provisions of Chapter 5, Part 2, Division 1 (commencing at Section 1621) of the Insurance Code. Any person not exempt from licensing pursuant to the provisions of such chapter shall obtain the requisite fire and casualty license pursuant thereto before engaging in any such transaction.

§ 2521. Limitation Investments Mortgage Guaranty Insurer.

No mortgage guaranty insurer may invest in notes or other evidences of indebtedness secured by a mortgage or other lien upon real property. This section shall not apply to obligations secured by, or contracts for the sale of, real property, which obligations or contracts of sale are acquired in the course of the good faith settlement of claims under policies of insurance issued by the mortgage guaranty insurer, or in the good faith disposition of real property so acquired.

Article 10.1. Investment Annuities

§ 2522. Authority.

This Article is promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Section 790.10 of the Insurance Code.

NOTE: Authority cited: Section 790.10, Insurance Code.

HISTORY
1. New Article 10.1 (Sections 2522, 2522.1–2522.16) filed 8–19–76; effective thirtieth day thereafter (Register 76, No. 34).

§ 2522.1. Prior Inconsistent Bulletins Superseded.

This Article supersedes Bulletin No. 73–14 and Bulletin No. 74–5, previously issued by this Department relating to the subject matter of investment annuities.

§ 2522.2. Purpose.

The purpose of this Article is to establish qualification procedures for the transaction of an investment annuity business in this State, policy form approval and advertising guidelines applicable to the issuance of investment annuity policies, and requirements for the establishment of segregated custodian accounts. This Department's review of and experience with investment annuities indicates that this Article is necessary due to the complexity of the product, the potential for abuses in marketing, and the possible effect upon the financial condition of the insurer. This Article establishes specific standards and guidelines for the transaction of an investment annuity business under the general authority of the Unfair Practices provisions of the Insurance Code in Sections 790 through 790.10.

§ 2522.3. Applicability.

This Article shall apply to all persons and entities specified in Insurance Code Section 790.01 and authorized to transact life insurance in this State.

§ 2522.4. General Requirements.

(a) An investment annuity policy is an individual policy or a group policy providing annuity payments to the annuitant(s) covered thereunder beginning immediately, or at some time in the future, based upon the value of a segregated custodian account, the assets of which are not managed by the insurer and which are irrevocably committed to the insurer as specified in the following subsection of this Article.

(b) Under investment annuity policies annuity purchase contributions consisting of cash, securities, or other assets, are the financial consideration for the investment annuity, and must be made to a segregated custodian account or accounts established pursuant to a written agreement with a fiduciary bank or trust company unaffiliated with the insurer or any affiliates of the insurer. The assets of the account must be irrevocably committed to the insurer and must be used, according to the provisions of the policy, to pay all current and deferred premiums, as due, to the insurer, taxes as applicable to the account, investment expenses relating to the account such as brokerage commissions and the charges of the custodian. Policies, other than when annuity benefit payments have commenced, shall provide for a cash surrender.

(c) Such investment annuity policies may provide benefits based on a single contribution (single purchase policies), or a series of contributions, reasonably anticipated to be made in predetermined specified amounts at predetermined specified times (recurring purchase policies), either of which may permit additional contributions at any time.

(d) The insurer must establish an Accepted Assets List, in accordance with Section 2522.10 of this Article, which is extensive in nature and expressed generally as to the kinds of investments acceptable to the insurer. The selection of investments within the account may be made by the annuitant in accordance with the Accepted Assets List of the insurer; provided, however, if the policyowner is other than the annuitant, and the policyowner has the investment discretion of the account, the policy may provide that the policyowner, rather than the annuitant, will select the investments. The selection of investments may be delegated to an appointed investment manager of the policyowner. The insurer shall not, directly or indirectly, manage the investment or reinvestment of assets in the account.

(e) The assets in the account shall be valued by the custodian at the end of each calendar year at fair market value on the date of valuation. "Account Market Value," as used in this Article, means the value, net of due or accrued taxes, custodian charges, investment expenses, and account market value premiums. The assets of any such account are not chargeable with liabilities arising out of any other business the insurer may conduct. Neither policyowners nor annuitants shall share in any of the profits or the losses of the insurer. There shall be no sharing of profits or losses among accounts. All policies shall be non–participating. If the insurer reduces premiums on larger annuity purchase contributions for a specified class of annuitants, such reduction shall be applicable to all members of the class.

(f) Premiums from the account may become due and payable to the insurer upon the receipts of annuity purchase contributions by the custodian, upon stated intervals based on the account market value, upon the death of the annuitant, upon the annuitant reaching a predetermined age, upon cash withdrawals or surrender of the policy or group certificate, upon such dates that immediately precede any benefit interval, or upon such other due date as specified in the policy. If after payment of pre-

miums on a due date, obligations to an annuitant or a beneficiary continue which are not funded by the premium payments, the proper amount of assets to fulfill such continuing benefit obligations shall remain in the account.

(g) All premiums, current or deferred, prescribed by the policy shall be actuarially determined to provide benefits for annuitants with allowance to the insurer for expenses, contingencies, and profits. Premiums reflect the fact that the account market value on which benefits are based may change at stated intervals. Premiums may be expressed either as percentages or stated dollar amounts, or a combination thereof.

(h) The schedule of premium rates and annuity rates applicable during the annuity payout period shall be constructed to provide a level fixed dollar annuity for a benefit interval and such benefit amounts will remain the same for successive benefit intervals so long as the account market value increases at a rate equal to the net assumed investment increment rate stated in the policy. If the account market value increases at a higher rate, the annuity payments in the succeeding benefit interval will be increased. If the account market value increases at a lower rate, the annuity payments in the succeeding benefit interval will be decreased.

(i) The insurer shall establish reserves for its benefit obligations, and the premiums received by the insurer for such obligations shall be invested by the insurer in the manner specified by statute for fixed dollar annuity reserves.

§ 2522.5. Qualification to Transact Investment Annuity Business in This State.

(a) No investment annuity policy shall be delivered or issued for delivery in this State by an insurer until the Commissioner is satisfied that the issuance of such policy is not hazardous to either the public or to the annuitants of such insurer. An insurer shall not be authorized to deliver or issue for delivery in this State an investment annuity policy unless the insurer has filed in form and substance, to the satisfaction of the Commissioner, the following:

(1) A statement of the actuarial assumptions upon which the investment annuities are to be issued and the plan and methods of administration and marketing of investment annuities, including advertising materials;

(2) A statement of the method of control, management and administration of the segregated custodian accounts, including the account reporting procedures to annuitants and to policyowners, if the policyowner has the investment discretion as to the account;

(3) Evidence of compliance with relevant tax laws and regulations and any relevant federal securities laws and regulations. Such evidence of compliance must be to the satisfaction of the Insurance Commissioner, and different standards of compliance may be required depending upon the scope of the Accepted Assets List and the types of assets appearing on such list, and the arrangement, if any, to offer or sell assets to fund the custodian account or accounts, or provide investment advice or investment management with respect to such assets (this includes affiliated broker–dealers licensed as life insurance agents);

(4) A full disclosure statement with respect to any person (including life agents) associated with the insurer and any broker–dealer who may recommend securities to annuitants, effect securities transactions on their behalf, or undertake to act as investment manager to the annuitant, in connection with the funding or maintaining of the segregated custodian accounts, and a commitment to provide disclosure with respect to any changes in such relationships;

(5) A full disclosure statement revealing the relationship with such custodian or any organization that may sell, issue or provide securities or other assets which may be held in any custodian account of any officers, directors or person owning or controlling 10% or more of the stock of the insurer or the proposed custodian and a commitment to provide disclosure of any subsequent changes in such relationships;

(6) A certification that there is no commitment, nor will the insurer at any time enter into a commitment, with any person to subsidize in any manner or by any means the cost of producing or handling the investment annuity business (including the custodian, transfer agent, service organizations but excluding any commission or other compensation to the producing life agent);

(7) A five (5) year projection, in a form prescribed by the Insurance Commissioner, of the development of statutory surplus arising from the operations of investment annuity contracts, which must include, but not necessarily be limited to, sufficient details of the methods employed in determining the separate items to enable the Department of Insurance to independently verify the application of the assumptions. The financial projections shall include the cost of commissions, data processing, salaries, general administration, and the resultant effect on surplus, and be based upon three separate assumptions with respect to the rate of writings:

(A) As developed assuming a level annual dollar amount of investment over the initial five (5) year period;

(B) Assuming an increase in the annual dollar amount of investment over the initial five (5) years increasing at the rate of 20% per year compounded annually;

(C) Assuming a decrease in the annual dollar amount of investment over the initial five (5) years, at the rate of 20% so that each year's dollar amount is 80% of the previous year's dollar amount of investment as each relates to the previous year's dollar amount of investment, as each relates to the consideration received by the insurer; and

(8) A statement that the insurer has complied with all of the other requirements of this Article.

§ 2522.6. Financial Reports and Projections Subsequent to Qualification.

(a) For the first five (5) years after qualification, the insurer shall file quarterly financial reports covering its investment annuity business separate and apart from all other business of the insurer, on a form provided by the Commissioner. Such quarterly reports must be related to the previously filed projections. The five (5) year projections initially submitted with the qualification material must be revised and resubmitted annually for the first five (5) years.

(b) The first quarterly report after qualification shall be due following the first full quarter after the original qualification to transact an investment annuity business.

(c) After the insurer has been qualified to transact such business for five (5) years, it will be required to file its financial report of investment annuity business on an annual basis, unless the Insurance Commissioner requests the insurer to file more frequently, together with its projections for the next year and verification of the projections for the previous years.

(d) The Department's review of the verification may result in additional capital and surplus requirements, restriction on writings or both.

§ 2522.7. Filing of Sales Materials.

(a) The word "advertisement," as used in this article, means any advertisement material, illustration, descriptive literature or other sales material of any kind relating to investment annuities. An insurer authorized to transact investment annuity business in this state is responsible for all advertisements of its product and shall not use in this state any advertisement which is false, misleading, deceptive or inaccurate. All investment annuity advertisements shall be filed with the commissioner not less than thirty (30) days prior to use. Revised versions of such filed advertisements shall be filed with the commissioner not less than thirty (30) days prior to use. A filed advertisement may be used if either: (1) thirty (30) days expire without notice from the commissioner that the advertisement is objectionable, or (2) the commissioner prior to that time indicates the advertisement is unobjectionable. The commissioner shall require an insurer to cease the use of any advertisement if any such advertisement is false, misleading, deceptive or inaccurate.

(b) All advertisements used in this state relating to investment annuities shall clearly state that the product being advertised is an investment annuity and an insurance product. An investment annuity shall be advertised in the name of the insurer; provided, however, that a life insurance agent appointed to represent the life insurer may advertise investment an-

nuities of such insurer if the advertisement has been approved as to form and content by such insurer and the advertisement discloses the name of the insurer. All agreements between the insurer and the custodian shall provide that the custodian shall not advertise investment annuities.

(c) An insurer shall not describe its investment annuity as a "Savings Annuity Plan," "Securities Annuity Plan," "Certificate of Deposit Annuity," a "Tax Saver Plan" or use words or phrases of similar import describing the assets which are on its Accepted Assets List. The insurer may describe its investment annuity as "investment directed," "investment annuity," "personal investment annuity," "retirement investment annuity," or other words or phrases of similar import. The use of any advertisement with the terms "low" or "low plan fees" or "low premiums" is a question of fact which will be determined based upon comparative information filed with the commissioner. Such terms as "tax deferred" or "tax sheltered" investing to provide the basis for future annuity payments may be used; provided, however, that earnings excludable from income tax shall not be described as "tax free." Annuity premiums shall not be described as "fees."

(d) All advertisements of investment annuities, other than invitations to inquire, shall contain a specific and complete disclosure explanation of all of the usual and customary charges made by a representative custodian for each type of investment transaction and clearly describe the initial premiums, and annual account market value premiums, and any other type of premium charges payable to the insurer, other than those required to provide benefits, and shall also disclose the amount payable as a sales commission or commissions. The disclosure of the amounts of commissions shall be stated either in dollars or in percentages related to the amount of the annuity purchase contribution or the amount of premium on the annuity purchase contribution. All advertisements must clearly state which charges are payable to the custodian by the policyowner.

(e) Illustrations of benefits payable under an investment annuity policy shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided, however, that nothing contained herein prohibits the use of hypothetical assumed rates of return to illustrate possible levels of benefits if it is clear that such assumed investment rates of return are hypothetical only. Such illustrations, if used, shall be prepared by the insurer or approved by the insurer prior to use. If assumed investment rates are used, at least one illustration must show the results if the net investment rate of return is one-half of the highest assumed investment return.

(f) Neither the insurer nor the life insurance agent shall describe or refer to any asset on the Accepted Assets List as assets, investments or securities approved by the Commissioner.

(g) Every insurer offering an investment annuity in this State shall establish and maintain a system of control over the content, form, and method of dissemination of all advertisements of its investment annuity policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised. In addition to filing all such advertisements with this Department, all such advertisements shall be maintained by the insurer for a period of either four (4) years subsequent to use or until the filing of the next regular Report of Examination of the insurer, whichever is the longer period of time.

§ 2522.8. Filing and Approval of Policy Forms.

(a) Since an investment annuity policy, the custodian account agreement and other related documents are complex, and since the annuity benefits vary from year to year based upon the premium payable from the segregated account which will reflect the investment performance of the assets in the segregated custodian account, it is in the public interest to require the filing and approval of investment annuity policy forms delivered or issued for delivery in this State and also the filing and approval of all documents whether attached to or used in conjunction with the policy.

(1) Investment annuity policy forms, as used in this paragraph and the preceding subsection, mean any individual policy or group policy, any application form and any documents, rider or endorsement attached to and made a part of the policies or used in conjunction with the policies, including the custodian account agreement form, the group certificate, the group enrollment card or form and the form or forms used to direct the investment of account assets. No such form shall be delivered or issued for delivery in this State, after the effective date of this Article, unless and until the policy form and any other documents described in this paragraph have been filed with and approved in writing by the Commissioner.

(2) While for the purpose of the insurance laws an investment annuity is not a variable annuity, the fees for approval of such policy forms shall be the same as the fees set forth in Section 2201(10), California Administrative Code, Title 10, Chapter 5, Subchapter 2, whether it is a group or an individual policy. In determining the applicable charge the Commissioner will consider all of the sections of Subchapter 2. The provisions of Insurance Code Section 12957 shall be applicable to withdrawal of approval of such investment annuity policy forms.

(3) Investment annuity policy forms shall contain provisions which comply with the following requirements:

(A) Group policies may be issued to employers or an association of employers to insure the employees of the employer(s) only, and shall provide that in the event the group policyholder terminates the group policy, the annuitant has the right to obtain an individual policy on terms not less favorable than those of the group policy. Group policies shall not contain any type of an experience rating provision or dividend provision. The approval of a group policy by the Commissioner for issuance to groups other than an employer or an association of employers will be on an instant case filing basis only.

(B) The policy shall provide that, in the event a prescribed premium is not received either because of a breach of the custodian's obligations under the custodian agreement or because of loss in the account other than loss from depreciation in the investment value, the insurer shall not be relieved of its obligation to make annuity payments thereunder.

(C) Neither the custodian account agreement nor the annuity policy shall impose a penalty on the annuitant for failure or delay of the custodian to pay to the insurer any premiums or taxes due the insurer, except the insurer may defer the payment of annuity benefits or other benefits for a period not to exceed sixty (60) days following receipt of such premium or tax payment, at which time all delayed annuity payments shall be made.

(D) All policy forms shall specify that the forms shall be construed according to and be governed by the laws and regulations of the state where the policy is delivered. When the policy or an application attached to the individual policy clearly states the actual state of delivery of the policy, the requirement of the preceding sentence may be complied with by a reference to the documents being construed according to and governed by the laws and regulations of the state where the policy is delivered.

(E) An investment annuity policy shall be either a Single Purchase Investment Annuity Policy or a Recurring Purchase Investment Annuity Policy. Single purchase policies shall have a minimum single initial annuity purchase contribution of not less than ten thousand dollars ($10,000.00), and subsequent optional annuity purchase contributions, if any, shall not be less than one thousand dollars ($1,000.00). The insurer may, in the policy, set forth the maximum amounts of permissible additional purchase contributions. Recurring purchase policies shall have anticipated minimum purchase contributions of not less than twelve hundred dollars ($1,200.00) per year, payable at such specified frequencies within each year as permitted by the policy.

(F) The insurer may issue recurring purchase annuities of less than twelve hundred dollars ($1,200.00) per year on a payroll deduction or reduction basis or an employer contribution basis, if the insurer files with the Commissioner, in addition to the information otherwise required, a justification of such lower contribution levels, including that the issuance of such annuities will not adversely affect the solvency or operations of the insurer, explaining the relevant characteristics of the market to be

serviced, the need for the lower contribution level, and any other information which the Commissioner may require. Such approvals, if granted by the Commissioner, will be granted on an instant case basis only for the employees of the specified employer.

(G) Every individual investment annuity policy shall have printed on the application furnished to the applicant a notice stating, in substance, that, at any time within ten (10) days after the signing of the application, the applicant may request cancellation of the application by delivering or mailing notice to that effect to the insurer or to the life insurance agent through whom the policy was purchased, and that all annuity purchase contributions paid shall be returned to the applicant. Neither the insurer nor the custodian shall be required to comply with any investment instructions during such ten (10) day period, and any such annuity purchase contributions which are received may remain unprocessed during such ten (10) day period, unless such ten (10) day period to request cancellation is specifically and separately waived in writing on the application by the applicant.

(H) A clear and prominent statement shall appear on the first page of the policy and the group certificate and clearly and prominently in the application stating:

1. That the policy is an investment annuity policy; and

2. That the annuity benefits payable will vary at established intervals and are based upon the premiums payable from the segregated account which will reflect the net investment performance of the assets in the segregated custodian account.

(I) The policy shall contain a provision which clearly specifies and defines the assumed investment increment factor to be used in computing the dollar amount of investment annuity benefits or other contractual payments or value thereunder, and a provision which shall guarantee that neither the expenses of the insurer nor the mortality experience of the insurer shall adversely affect such dollar amounts. "Expenses," as used herein, may exclude some or all taxes, as stipulated in the policy.

(J) The policy shall contain a provision which provides that in computing the dollar amount of investment annuity benefits or other contractual payments or values under an investment annuity policy, the assumed investment increment rate established by the insurer shall not exceed 6% per annum. A higher rate or lower rate may be selected by the policyowner, subject to the approval of the insurer.

(K) The policy shall contain a table of the premiums payable and the annuity benefits provided during the lifetime of the annuitant and, if the policy or annuity continues after the death of the annuitant, the premiums payable, if any, and the annuity benefits provided. Such table shall specify the net assumed investment increment rate used by the insurer. In the event the policyowner selects an assumed investment increment rate higher or lower than the rate stated in the policy, an appropriate premium and annuity schedule, based upon the rate selected, shall be issued by the insurer as an amendment to the policy and furnished to the policyowner and to the annuitant if the annuitant is a person other than the policyowner.

(L) The policy and the group certificate shall contain a provision stating that annuity benefits are based upon premiums paid from the segregated custodian account.

(M) The policy shall contain a provision that the policyowner, or the policyowner's chosen investment manager, and not the insurer, shall direct the custodian as to the investment of the assets in the account from time to time during the time the annuity policy remains in force.

(N) In the event a policy provides any penalty for a default in the payment of annuity purchase contributions or of premiums from the account, the following non–forfeiture provisions shall be included in the policy giving the policyowner the right to correct such default.

1. A provision that there shall be a period of grace of one (1) month within which any payment may be made and during which period of grace the policy shall continue in force. The policy shall include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values, if any, under the policy and arising therefrom.

2. A provision providing that at any time within two (2) years from the date of default in making payments during the life of the annuitant under a recurring purchase contract, unless the policy has been surrendered and the surrender value has been paid, the policy may be reinstated upon payment of such overdue payments, and of any indebtedness to the insurer on the policy, including interest on such indebtedness at a rate not to exceed 6%. The policy shall include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the policy and arising therefrom. In lieu of a reinstatement provision, the policy may contain another provision more favorable to the policyowner and annuitant.

3. A provision specifying the options available in the event of default in annuity purchase contributions or premium payments. Such provision may include an option to request either a partial or a complete surrender of the policy for account market value, less a surrender charge to the insurer. Such a provision may also include an option to receive a paid–up annuity if the policy has not been surrendered. The amount of such paid–up annuity may be subject to a minimum established by the insurer and shall be determined by applying the account market value at the annuity commencement date. The minimum partial cash surrender may be a reasonable amount of the market value of the segregated account of the annuitant, and the policy may contain other reasonable restrictions if the market value of the segregated account is less than five thousand dollars ($5,000.00).

(O) The policy shall contain a provision that it is incontestable by the insurer after the policy has been in force for two (2) years during the lifetime of the annuitant.

(P) The policy shall contain a provision or provisions clearly stating the premiums charged on annuity purchase contributions, the premiums charged on the account market value and the calculation of any other premiums or charges made by the insurer to provide benefits under the policy.

(Q) The policy shall contain in addition to the other provisions required by this Article, but not necessarily limited to, the following appropriate provisions relating to: Entire Contract; Beneficiary Designation; Ownership; Assignment; Misstatement of Age or Sex; Proof of Death; Proof of Survival and Identity, and Facility of Payment.

(R) Subject to other provisions of this Article the policy shall contain a provision for the partial or the complete surrender of the policy prior to the commencement of life contingency annuity benefits.

(S) Each group certificate shall contain in addition to other group certificate provisions required by this Article, but not necessarily limited to, the following:

1. The name and home office address of the insurer;

2. Identification of the master policy;

3. A description of the coverages and benefits offered thereunder together with any exceptions, limitations, and restrictions;

4. Appropriate provisions with respect to assignment and beneficiary designations, incontestability and conversion;

5. Provisions with respect to the right to terminations, withdrawal and cash surrender benefits, if any, of the certificateholders;

6. Optional annuity date provisions, if any, and

7. Settlement options.

(T) A group investment annuity policy shall not contain any provision which permits or provides in any manner whatsoever for any reimbursement to the group policyholder or certificateholder of the expenses of administration or any other form of compensation, directly or indirectly, from the insurer. This provision shall not prohibit the payment of commission to a life agent who may be a policyholder or certificateholder.

(U) 1. If the policyowner is other than the annuitant, the policy shall state (i) whether the policyowner or the annuitant shall select the invest-

ments, and (ii) whether the policyowner, the annuitant, or both, may make annuity purchase contributions under the policy.

2. All custodian reports shall be furnished to the person who has the right to direct the investments in the account.

3. In the event the policy is a group policy, the group policyholder shall not exercise the right of selection of investments unless the group policyholder makes a contribution to the segregated custodian account.

§ 2522.9. Custodian Account Agreements.

(a) A custodian account agreement to be used in conjunction with an investment annuity policy shall be filed by the insurer with the Commissioner for approval and shall be attached to and made a part of the policy. If the policy is a group policy, a copy of the custodian account agreement shall be delivered to the annuitant with the group certificate. A custodian agreement shall not relieve the insurer from any responsibilities or obligations imposed upon the operations of its investment annuities by any law or regulation.

(b) Until transmitted to the insurer as premium payments, the assets supporting the benefits provided to each annuitant shall be maintained in a segregated custodian account with an independent bank or trust company having authority to act in a fiduciary capacity and not affiliated with the insurer or any of the affiliates of the insurer.

(c) The choice of the custodian is to be made by the policyowner subject to the approval of the insurer; however, the insurer may recommend one or more of its approved custodians, or it may, for reasonable and just cause, refuse to approve a proposed custodian selected by the policyowner, or as provided in paragraph (26) of subsection (d) of this Section, the insurer may give written notice to the policyowner requiring the appointment of a successor custodian. The reason of the insurer for any such action shall be neither arbitrary nor capricious.

(d) A custodian account agreement shall clearly identify the custodian and either the custodian agreement or the policy (except where otherwise herein stated) shall contain provisions relating to the authority, responsibility and duties of the custodian and shall comply with the following requirements and contain the following provisions.

(1) The policyowner, or the policyowner's chosen investment manager, and not the insurer, shall direct the custodian as to the investment of the assets in the account from time to time during the time the annuity policy remains in force. This requirement must be stated in the custodian account agreement.

(2) A provision in the agreement that all assets in an account including dividends, interest and other income or distributions from the assets, shall be irrevocably committed to the payment of premiums under the annuity policy, the payment of charges of the custodian, investment expenses such as broker's commissions and the remittance to the insurer of such amounts necessary for any state or federal tax applicable to the account and any other necessary and proper charges, and the custodian may be authorized to apply cash and other assets held in the account to the payment thereof or to reimburse itself therefrom.

(3) A provision providing for access to the records of the custodian by the insurer or its designee during reasonable business hours for the purpose of verifying all matters relating to the segregated accounts.

(4) The custodian agreement shall contain a provision providing that in the event of a change of custodian, the custodian shall continue to hold and administer the custodian account until the successor custodian has been appointed, approved by the insurer, and the successor has accepted the transfer of the account and the assets therein.

(5) A provision that in the event the custodian resigns, the custodian shall give not less than ninety (90) days notice, and, if the custodian resigns, or the insurer removes the custodian, either the custodian or the insurer shall bear the expenses resulting from such change of custodian. If the policyowner removes the custodian, the agreement shall specify who shall bear the expenses and it may provide that the custodian account shall bear the expenses resulting from such change of custodian. If the custodian is removed, the policyowner shall appoint a successor custodian acceptable to the insurer within forty–five (45) days. If the custodian resigns, the policyowner shall appoint a successor custodian acceptable to the insurer within ninety (90) days from the date of the resignation notice. If the policyowner fails to appoint such a successor custodian within the respective number of days set forth herein in the case of removal or resignation, the insurer may appoint a successor custodian.

(6) A provision in the agreement that it shall be the responsibility of the custodian to value the assets in the account at the end of each calendar year and at such other times as contractually required to carry out the provisions of the policy. Such valuation shall be based on the fair market value of such assets on the date of valuation. The custodian shall remit promptly to the insurer the premiums due under the terms of the policy; provided, however, that the agreement may provide that the custodian may rely upon written statements of the insurer as to premiums due or any other amounts due to the insurer.

(7) A provision in the agreement that within thirty (30) days after the receipt of notice from the insurer that a premium is due and payable by reason of the death of the annuitant or the annuitant having attained a predetermined age or date, the custodian shall furnish the insurer and the insurer shall furnish the annuitant or whoever then shall have succeeded to the annuitant's rights and obligations under the custodian account agreement:

(A) A statement listing all the assets in the account, the fair market value of each asset and the aggregate fair market value of all assets in the account, all as of the premium due date; and

(B) A statement setting forth the premiums due and related benefit payments.

(8) A provision in the agreement stating the usual and customary charges made by the custodian for the various types of transactions. Such statement shall provide that the custodian shall not increase the schedule of charges more often than once every twelve (12) months. The statement of charges of the selected custodian shall be either in the custodian account agreement or in a rider attached thereto.

(9) Provide for the safekeeping and custody of the securities and other assets in the custodian account.

(10) Provide for the execution of all declarations, affidavits, certificates of ownership and other necessary documents required in collecting principal and income payments.

(11) Provide for collection of the annuity purchase contributions, the recording of dividends, interest, proceeds of maturing or called securities and other income to be credited to the segregated custodian account in accordance with the agreement.

(12) Provide for exchanging temporary securities certificates for permanent certificates.

(13) Provide for selling all stock rights and warrants, as these occur.

(14) Provide for notifying the annuitant with respect to requests for tender of assets and offers to exchange assets as they occur.

(15) Provide for the registration of assets by the custodian and that any re–registration, transfer or deposit shall not relieve the custodian of any of its duties or obligations under the agreement.

(16) Provide that the custodian shall execute orders for purchase, sale or exchange of assets and make settlement in accordance with the normal rules applicable to such commercial transactions.

(17) Provide for maintaining a complete record of all transactions with respect to the account.

(18) Provide for determining the fair market value of the first annuity purchase contribution as of the effective date of the agreement, any subsequent annuity purchase contribution or contributions as of the date when deposited in the account, and the assets held in the account at the end of each calendar year as provided above.

(19) Provide that the custodian will determine, based on the information received from the insurer, the premiums due, as provided above in paragraph 6, and the applicable annual annuity as contemplated by the policy.

(20) Provide that the custodian shall be required to carry out investment instructions received in writing from the policyowner or his autho-

rized investment manager, in a timely and responsible manner, unless such instructions are not in accordance with the terms of the agreement. The custodian shall issue a quarterly written report to the policyowner or investment manager not more than thirty (30) days after the end of the quarter confirming that the investment instructions received within thirty (30) days prior to the end of the quarter have been executed and performed.

(21) Provide that the custodian shall agree to sell, purchase or exchange for the benefit of the account, assets held in the account pursuant to instructions received from the policyowner and in the compliance with the agreement.

(22) Provide for making available the listing of accepted assets in generic form which may be held in the custodian account by the policyowner and specifying any limitations on the investing power of the policyowner. The agreement shall contain or have attached to it the Accepted Assets List and provide that, if the Accepted Assets List is amended by the insurer, the amendments will be furnished to the person who has the investment discretion.

(23) Specify the grounds upon which an asset may be removed from the Accepted Assets List of the insurer, including the time to be given to the policyowner to direct sale of such asset after notice from the insurer to both the annuitant and the custodian to remove the asset and the action, if any, that the custodian will take if the asset is not sold within the specified time. (Limitations may be based upon the compatibility of the insurer and the custodian's administrative procedures for investing and accounting, and upon the asset having a reasonably ascertainable market price available from regular market activity as specified in Section 2522.10(a) of the Article.)

(24) Provide that, in connection with the voting of shares, it shall be provided that, if the custodian reserves the right to execute proxies to vote shares, it must be pursuant to the annuitant's or, when the policyowner has the investment discretion as to the account, the policyowner's right at any time to give instructions regarding the execution of proxies.

(25) Provide that, in connection with premiums and disbursements, the custodian shall agree to promptly remit premiums, taxes and assessments from the account in cash to the insurer as provided in the policy. The assets held in the account and the dividends, income and distributions on such assets shall be applied only to the payment of the annuity premiums to the insurer under the policy, the charges of the custodian and other charges as may be specifically set forth in the agreement. It shall be clearly set forth that none of the assets, dividends, interest, income and distributions thereon shall be distributed or distributable by the custodian to any owner, annuitant, joint annuitant (or their respective heirs, executors, administrators or personal representatives) or to any beneficiary or assignee. When cash funds are required for any purpose provided in the agreement and such funds are not currently available out of annuity purchase contributions and out of dividends, interest, income and distribution, and the custodian has not received specific selling instructions from the annuitant as to particular assets, the custodian must sell assets pursuant to a fair, just, equitable and objective standard which shall be set forth in the agreement, and the agreement may provide for the custodian to sell the most recently acquired asset.

(26) Provide that the insurer retains the right to give written notice to the policyowner that it no longer approves of the custodian and that the insurer may require the removal of the custodian for any reason which is not arbitrary or capricious, including the following reasons:

(A) Failure of the custodian to provide all necessary information to the insurer or the policyowner or the annuitant in a timely and accurate manner;

(B) Failure of the custodian to remit any and all charges, premiums, annuity purchase contributions, assessments, taxes and similar items;

(C) The occurrence of any event that would have a material affect upon the financial condition or business reputation of the custodian including, but not necessarily limited to, its bankruptcy, material litigation against the custodian, state or federal regulatory action against the custodian, and

(D) Any other reasonable, just or good cause.

(27) Except as to amounts due to the insurer, provide that the assets held in the account shall not be sold, assigned, discounted or pledged as collateral for any purpose nor shall they be subject to any legal process to levy upon or cash the same for payment of any claims against the policyowner, the annuitant, the joint annuitant, if any, beneficiary or other person entitled thereto except as to the extent permitted by law.

(28) Provide that the agreement shall be binding upon the assignees, executors, administrators, personal representative and heirs of the policyowner, annuitant, the joint annuitants, if any, any beneficiary and any other person or persons entitled thereto.

(29) The agreement shall provide with respect to policy ownership and assignment that:

(A) If the annuity policy, when issued, is owned by a person other than the annuitant, all rights, titles, interest and obligations under the agreement with respect to such annuitant shall vest in the owner, and

(B) Any and all rights, title and interest may be assigned and the assignment shall be effective when notice of such assignment is received at the home office of the insurer.

(30) The agreement shall provide that it is to be construed and governed in accordance with the laws of the state where the policy is delivered.

(31) The agreement shall provide that the custodian shall perform all other duties and services consistent with the purposes and intent of the agreement.

(32) The custodian account agreement shall contain all of the applicable provisions provided in this Article, but is not necessarily limited thereto, and may contain other provisions or contractual requirements.

§ 2522.10. Accepted Assets List.

(a) The insurer shall establish and file for approval by the Insurance Commissioner a listing of accepted assets which may be held as investments in a segregated custodian account. The Accepted Assets List shall be extensive and expressed generally as to kinds of investments acceptable. Acceptability as to either a class of asset or as to any specific assets within a class shall be based upon the asset having a reasonably ascertainable market value available from reports of regular market trading or established by recurring commercial transactions not involving trading in assets, and compatibility of the asset with administrative procedures established by the insurer for the investing and accounting of assets within the account.

(b) The insurer shall also file with the Commissioner its standards for the amendment of its Accepted Assets List by the addition or deletion of classes of assets. The procedures for the addition or deletion of specific assets within a class shall also be filed at the time of filing the Accepted Assets List. In the event an asset is deleted as an acceptable asset, such asset may be required to be sold and the proceeds reinvested or its acceptability may be terminated with regard to future investments only.

(c) In the event that the insurer amends the Accepted Assets List or deletes a specific asset, it shall file notice of such action and the reason for such action, as specified in subsection (h) below, with the Insurance Commissioner.

(d) The following is an example of an Accepted Assets List:

(1) Securities listed and traded on the New York Stock Exchange, the American Stock Exchange or regional stock exchanges or successors to such exchanges having the same or similar qualifications;

(2) Securities listed on the NASDAQ System;

(3) Shares of an investment company registered pursuant to the Investment Company Act of 1940 other than an investment company affiliated with either the insurer or the custodian. Where such an investment company issues book shares in lieu of share certificates, such book shares shall be deemed to be adequate evidence of ownership;

(4) Obligations of or guaranteed by the United States government, the Canadian government, any state (or province of Canada), or municipality or governmental subdivision of a state;

(5) Savings accounts, passbook accounts and certificates of deposit issued by financial institutions which are insured by the FDIC or FSLIC, cash, and credit union loan accounts as such credit union loan accounts are otherwise permitted;

(6) New bond or debt issues which may reasonably be expected to be listed on an exchange regulated by the Securities Exchange Act of 1934;

(7) Life insurance the face amount of which is incidental in relationship to the anticipated annuity benefit payments. In accordance with current Internal Revenue Rulings and for the purpose of this Article, the word "incidental" as used in the preceding sentence means that life insurance shall be considered incidental if the face amount does not exceed one hundred(100) times the anticipated monthly annuity computed as if the percentage of net annual increase in the account value will be equal to the assumed investment increment rate underlying the actuarial assumption on which the amount of monthly annuity is based;

(8) Such other classes of assets which meet the standards of acceptability of the insurer after filing of such list with the Insurance Commissioner.

(e) The above example of classifications indicates the general classes of acceptable assets within which most individual assets will be acceptable. Acceptance of any particular assets, however, may be made dependent on its procedural compatibility with the insurer's systems and the insurer's general standards of acceptability.

(f) The policyowner shall have only one custodian at any one time. It is recognized that operational differences exist among different custodians and, therefore, some particular assets within an insurer's general class of accepted assets may not be available as investments with all custodians.

(g) The policy or the custodian account agreement, or both, may provide that it shall be the responsibility of the policyowner or the annuitant or the investment manager, if any, to determine, prior to purchase or exchange of an asset, that it is an acceptable asset.

(h) The insurer shall not reserve the right to approve the selection of assets within any account if such asset is being currently accepted for any segregated custodian account, The insurer may amend its Accepted Assets List in accordance with standards filed pursuant to subsection (b) of this Section and shall file notice of such changes in accordance with subsection (c) of this Section as follows:

(1) If an asset is removed as an accepted asset for future purchases because the asset is no longer available for purchase due to the suspension of trading in the asset, the withdrawal from sale of the asset by the issuer of the asset or for similar reasons, the insurer may take removal action without prior notice to the Commissioner; the insurer shall notify the Commissioner of such action as soon as reasonably possible.

(2) If the asset is removed as an accepted asset for future purchase because the asset no longer meets the standards of the insurer of acceptability as filed with the Commissioner, the insurer may take such removal action and must file notice of such action within seven (7) business days of the time of such action;

(3) If the asset is removed as an accepted asset for future purchase and the insurer requires the sale of such asset, the insurer may take such action thirty (30) days after the filing of notice with the Commissioner of such intended action if the Commissioner has not given notice of objection to such action prior to such thirty (30) days or has indicated no objection prior to such thirty (30) days.

§ 2522.11. A Statement Shall Be Furnished Applicants for Investment Annuities.

(a) A statement containing the following information shall be furnished to an applicant upon request and prior to the execution of an application or group enrollment form.

(1) A summary explanation in non–technical terms of the principal features of the policy and of the manner in which any benefits will vary based upon premiums payable from the segregated custodian account which will reflect the investment experience of the assets in the account.

(2) A listing of the kinds of assets (investments) which are acceptable investments within a custodian account.

(3) A specific and complete schedule of all premiums and a specific and complete current custodian fee schedule which clearly discloses the usual and customary charges imposed by the custodian, including the charges for each type of investment transaction. Such custodian fee schedule shall specify that the custodian shall not increase the custodian account charges more than once each twelve months. A disclosure of the amount of the premiums payable as commissions for the sale of the investment annuity. Such disclosures shall comply with the requirements of subsection (d) of Section 2522.7 of this Article.

(4) A statement of the federal income tax liabilities applicable to the policy, and an explanation of the state premium tax.

(5) A prominent statement with respect to the fact that the custodian cannot return any assets of the account to the policyholder, policyowner or annuitant.

(6) Subject to the approval of the Commissioner, the insurer may include such other relevant information as the insurer deems appropriate.

(b) The form or forms containing the above specified information required to be furnished to applicants shall be filed with the Commissioner prior to any use thereof and shall not be used until approved in writing by the Commissioner.

§ 2522.12. Custodian Reports.

(a) Any insurer delivering or issuing for delivery in this State any investment annuity policy shall require the custodian to provide the policyowner, if the policyowner has the investment discretion as to the account, and to the annuitant at his or her last known address a report containing, at a minimum, the following information:

(1) Within thirty (30) days after the end of each calendar year, the custodian shall furnish the policyowner, if the policyowner has the investment discretion as to the account, and to the annuitant, if other than the policyowner, and the insurer with a statement of:

(A) Premiums, taxes, charges, assessments, if any, and transactions within the account since the last such statement, and

(B) A list in detail of all of the dividends, interest and other income and other assets in the account, the market value of each asset of the annuitant, and the aggregate fair market value of all of the assets in the annuitant's account, all as of the end of such calendar year.

(2) The term "transactions" includes, but is not limited to, the sale of assets sold or liquidated for the purpose of providing the necessary funds to pay such premiums, taxes, charges, expenses and assessments.

(3) Within thirty (30) days after the date any premium, based on the value of the account, falls due, the custodian shall furnish the insurer, and the insurer shall furnish the annuitant with:

(A) A statement listing all the assets in the account, the fair market value of each asset, and the aggregate fair market value of all assets in the accounts, all as of the premium due date, and

(B) A statement setting forth premiums due and related annuity payments.

§ 2522.13. Premium Tax.

No charge shall be made against the segregated custodian account for a premium tax until such a premium tax is actually due and payable. Section 28 of Article XIII of the Constitution is applicable to investment annuities.

§ 2522.14. Definitions.

The use in this Article of any definition or statement which directly or indirectly defines a word or phrase in the provisions of policy forms and the custodian agreement does not prohibit the insurer from using other words or phrases with the same generic source or meaning to state or define the same subject matter in the provisions of policy forms and the custodian agreement if the words or phrases are not misleading or are defined to clearly state the meaning of such words or phrases.

§ 2522.15. Agent Licensing Procedure.

The sale of investment annuity policies by a life insurance agent does not require licensing as a Variable Contract Agent.

§ 2522.16. Severability Provision.

If any section or portion of a section of this Article, or the applicability thereof to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of this Article, or the applicability of such provisions to other persons or circumstances, shall not be affected thereby.

Article 11. Separate Account or Accounts—Variable Contracts

§ 2525. Authority.

These regulations are promulgated pursuant to the authority granted the Insurance Commissioner by the provisions of Section 10506(h) of the Insurance Code.

NOTE: Authority cited: Section 10506, Insurance Code.

HISTORY

1. New Article 11 (Sections 2525, 2525.1, 2525.2, 2526, 2526.1–2526.3, 2527–2530, 2530.1, 2531–2533, 2533.1) filed 4–4–72 as an emergency; effective upon filing (Register 72, No. 15).
2. Certificate of Compliance filed 7–17–72 (Register 72, No 30).

§ 2525.1. Purpose.

The purposes of these regulations are to set forth rules and procedural requirements which the Insurance Commissioner deems necessary to implement the provisions of Section 10506 of the Insurance Code concerning the issuance and delivery of variable contracts in California, the payment of benefits thereunder, the manner in which the separate accounts required thereunder shall be established, maintained and administered and the administration of Article 16 (commencing with Section 1758.1), Chapter 5, Part 2, Division 1, of the Insurance Code relating to variable contract agents.

HISTORY

1. Amendment filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

§ 2525.2. Definitions.

(a) The term "variable contract," when used in these regulations shall mean any policy or contract which provides for life insurance or annuity benefits which vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, in accordance with Section 10506 of the Insurance Code. A policy or contract providing fixed annuity benefits during the annuity payment period shall be deemed to be a "variable contract" if the amount of such benefits depends, prior to the commencement date of the annuity payments, upon the investment experience of any separate account or accounts maintained for such policy or contract.

(b) "Agent," when used in these regulations, shall mean any person licensed as a life and disability or life only agent under the provisions of Chapter 5 (commencing with Section 1621), Part 2, Division 1, of the Insurance Code, more particularly defined in Section 1626 thereof.

(c) "Variable contract agent," when used in these regulations, shall mean an agent licensed to transact, or required to be licensed to transact, variable life insurance or variable annuity contracts by Article 16 (commencing with Section 1758.1), Chapter 5, Part 2, Division 1, of the Insurance Code.

§ 2526. Obtaining Certificate Permitting Transaction of Variable Contract Business.

No insurer shall deliver or issue for delivery in this State any variable contract until it has received in writing from the Insurance Commissioner a certification that he is satisfied that such insurer meets all the standards for transacting such business required by Section 10506. Such certification may be obtained by filing an application with the Insurance Commissioner together with supporting documents and paying the minimum $100 filing fee therefor required by Section 10506.1; and in case of a domestic insurer, agreeing to pay such additional amount as may be assessed by the Insurance Commissioner pursuant to said Section 10506.1. Such application shall be verified by an executive officer of the insurer.

§ 2526.1. Application of Domestic Insurers.

The application of a domestic insurer to write any variable contract shall include the following:

(a) A copy of the resolution of its board of directors, certified by the secretary or equivalent officer under corporate seal to be a full and true copy thereof, authorizing the establishing of one or more separate accounts for the purposes authorized by Section 10506.

(b) A copy of each written agreement in accordance with which each such separate account is to be established, maintained and administered, including for informational purposes a copy of each variable contract proposed to be delivered or issued for delivery in California.

(c) A statement of the additional amount, if any, of the insurer's assets, not otherwise received from variable contract holders for deposit in such a separate account, which have been allocated to a separate account pursuant to the authority of Section 10506(b). No more than 1% of its admitted assets, or 5% of the excess of its admitted assets over its liabilities and required reserves, both as of the preceding December 31, whichever is the smaller, may be so allocated.

(d) A statement of the history, organization, and ownership and control of the insurer. Any changes in organization, ownership and control which are contemplated shall also be set forth. Reference to past official examination reports, whether by California or other insurance regulatory authority, if appropriately brought up to date, is acceptable. Similarly, reference to other records bearing upon such matters, which have become part of the Commissioner's official files, are acceptable.

(e) A brief balance sheet statement of assets, liabilities, capital and surplus, as shown by its last filed Annual Statement. The Annual Statement filed will be relied upon for details.

(f) A complete statement of the plan and methods, including the marketing methods for the transaction of the variable contract and related business, which shall show:

(1) The status of the insurer of each of the separate accounts with the Federal Securities and Exchange Commission, including

(A) Any exemption granted under Section 3(c) (11) of the Investment Company Act of 1940 and Section 3(a) (2) of the Securities Act of 1933;

(B) The current prospectus and registration statement required by the Securities Act of 1933.

(2) If any variable contract is to be issued without a prospectus, an explanation as to marketing methods, and the Commissioner may request, for informational purposes, a copy of the advertising or solicitation material.

(3) The methods of control and management of each separate account, including the voting rights, if any, of participants, how they are exercised and their relation to the voting rights, if any, of members and shareholders of the insurer.

(g) If the insurer has not been engaged actively in the insurance business for at least five years under substantially the same management and control, a biographical affidavit on form prescribed by the Commissioner may, in the discretion of the Insurance Commissioner, be required for each of the executive officers, members of the board of directors and each natural person who owns 10% or more of the voting stock of the insurer.

(h) The identity and the experience and qualification of each of the persons charged with the investment management of each separate account, together with any other presentation which the insurer desires to make to establish the adequacy of the investment management which the insurer is providing. Such showing shall be such as to satisfy the Insurance Commissioner as to the experience and qualification of such management to effectively manage the investment program or programs envisaged by the agreement under which the separate account is established and maintained. A biographical affidavit in the form required by Paragraph (g) hereof may be required for each such manager.

(i) If the insurer is a subsidiary of an admitted insurer, or affiliated with such insurer by common control or management, it may be deemed by

the Commissioner that the history, the reputation, the character, responsibility and general fitness of officers and directors, the adequacy of investment management as evidenced by past results, and the basic financial soundness of the parent insurer or the controlling affiliate satisfy these regulations.

Subsequent to qualification, any amendments to the above mentioned resolution of the Board of Directors, agreement establishing a separate account, variable contract, registration statement or prospectus, and any substantial change in management shall promptly be filed with the Commissioner for review as to continuance of qualification standards required by law.

HISTORY

1. Amendment filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

§ 2526.2. Application of Foreign Insurer.

The application of a foreign insurer, including a Canadian insurer, shall include all of the matters required of a domestic insurer, except those specified in Paragraph (a) of Section 2526.1 hereof. The Commissioner shall give due regard to the regulatory activities of the applicant's domiciliary state in passing upon the qualifications of such foreign insurer to do a variable contract business in California. If the Commissioner requires, a foreign insurer shall furnish a copy of the statutes and regulations of its domiciliary state under which it is authorized to transact a variable contract business and which regulate such transaction.

§ 2526.3. Certificate of Qualification Required.

If the Commissioner, after review of the application for certification of qualification to engage in the variable contract business, is satisfied that the insurer meets the statutory requirements of Section 10506 and its proposed operations will not be such as to be hazardous to the public or its policyholders in this State, he shall issue his certification of such conclusion as provided in Section 2526 hereof.

§ 2527. Separate Account or Accounts: Non–Variable Contracts.

A domestic insurer may file under Section 10506 of the Insurance Code resolutions and agreements for any separate account or accounts maintained for policies and contracts which provide only fixed dollar annuities. These regulations being designed primarily for variable policies or contracts, are applicable to such a fixed dollar separate account only insofar as these regulations are relevant to that type of operation. The required approval by the Commissioner can be granted when filings are made in compliance with the basic requirements of subsections (a), (b), (c), (d), (e), (g) and the first sentence of (h) of Section 10506 of the Insurance Code to the extent such requirements are relevant to any such fixed dollar separate account.

§ 2528. Separate Account or Accounts.

A domestic insurer issuing variable contracts shall establish one or more separate accounts pursuant to Section 10506 of the Insurance Code, subject to the following provisions:

(a) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in Paragraph (b), (i) amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this State governing the investments of life insurance companies and (ii) the investments in such separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(b) Reserves for

(i) benefits guaranteed as to dollar amount and duration and

(ii) funds guaranteed as to principal amount or stated rate of interest may be maintained in a separate account if a portion of the assets of such separate account at least equal to such reserve liability is invested in accordance with the laws and regulations of this State governing the investments of life insurance companies. Such portion of the assets also shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company. If a variable contract includes incidental minimum guarantees as referred to in Section 2530(d) (3), this paragraph shall apply only to the reserve for any excess of such minimum guarantees over the reserves for the benefits that would be payable under the contract if there were no such minimum guarantees.

(c) With respect to 75% of the market value of the total assets in a separate account no insurer shall purchase or otherwise acquire the securities of any insurer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate account in such security taken at market, would exceed 10% of the market value of the assets of said separate account; provided, however, that the Commissioner may waive such limitation if, in his opinion, such waiver will not render the operation of such separate account hazardous to the public or the policyholders in this State.

(d) Unless otherwise permitted by law or approved by the Commissioner, no insurer shall purchase or otherwise acquire for its separate accounts the voting securities of any issuer if as a result of such acquisition the insurance company and its separate accounts, in the aggregate, will own more than 10% of the total issued and outstanding voting securities of such issuer; provided, that the foregoing shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interests in such accounts.

(e) The same separate account may not be used for both variable annuities and variable life insurance.

(f) The limitations provided in Paragraphs (c), (d), and (e) above shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, Section 1, et seq., Title 15, USC, provided that the investments of such investment company comply in substance with Paragraphs (c) and (d) hereof.

(g) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; provided, that unless otherwise approved by the Commissioner, the portion, if any, of the assets of such separate account equal to the insurer's reserve liability with regard to the benefits and funds referred to in clauses (i) and (ii) of Paragraph (b) shall be valued in accordance with the rules otherwise applicable to the insurer's assets.

(h) If and to the extent so provided under the applicable contacts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct.

(i) Notwithstanding any other provisions of law an insurer may

(1) with respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interest in such accounts ratably as determined by the company, or

(2) with respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably as determined by the company. Such committee, board or other body may have the power, exercisable alone or in conjunction with others to manage such separate account and the investment of its assets.

(j) No sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other invest-

ment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (i) by a transfer of cash, or (ii) by a transfer of securities having a valuation which could be readily determined in the market place, provided that such transfer of securities is approved by the Commissioner. The Commissioner may authorize other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

(k) The insurer shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account, except as may otherwise be approved by the Commissioner.

(*l*) The provisions of Sections 1101 through 1106 of the Insurance Code relating to conflicts in interest of officers and directors and other persons with authority in the management of the insurer's funds shall, in substance and insofar as they are reasonably applicable, apply to the investments of separate accounts and to members of any separate account's committee, board or body who have any function in relation to the investment of the account assets. No officer or director of such insurer nor any member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

HISTORY

1. Amendment of subsections (i) and (*l*) filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

§ 2529. Filing and Approval of Policy Forms.

All variable contract policy forms (The term "policy forms" as used in this Section means any individual policy delivered or issued for delivery in this State and any document attached to and made a part of such policy, and any group policy delivered or issued for delivery in this State and any document attached to and made a part of such group policy and any group certificate delivered pursuant to the provisions of such group policy.), including contracts providing fixed dollar benefits as may be included in the operation of any separate account, shall be submitted to the Commissioner prior to delivery or issuance for delivery in this State, and no such form shall be delivered or issued for delivery in this State until the use of such form has been approved in writing by the Commissioner. The fees for such approval shall be the fees set forth in Section 2202(a)(10), California Administrative Code, Title 10, Chapter 5, Subchapter 2. The provisions of Section 12957 of the Insurance Code shall be applicable to variable contract forms.

NOTE: Authority cited: Sections 10506(h), 12973.9, California Insurance Code. Reference: Section 10506, Insurance Code.

HISTORY

1. Amendment filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).
2. Amendment filed 10–4–79; designated effective 1–2–80 (Register 79, No. 40)

§ 2530. Contracts Providing for Variable Benefits.

(a) Any variable contract delivered or issued for delivery in this State shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of such variable or fixed benefits. Any variable contract providing benefits payable in variable amounts, including such a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a clear statement to the effect that the benefits thereunder are on a variable basis. As to any contract providing benefits payable in fixed amounts during the annuity payment period, such statements may be modified to reflect that the benefits, although guaranteed after the annuity commencement date, depend upon the experience of the separate account prior to the annuity commencement date.

(b) Illustrations of benefits payable under any variable contract shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of benefits.

(c) No individual variable annuity contract providing for the payment of periodic stipulated payments shall be delivered or issued for delivery in this State unless it contains in substance the following provisions or provisions which in the opinion of the Commissioner are more favorable to the holders of such contracts:

(1) A provision that there shall be a period of grace of 30 days or of one month, within which any stipulated payment to the insurer falling due after the first payment may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values under the contract arising therefrom:

(2) A provision that, at any time within 2 years from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom;

(3) A provision specifying the options available in the event of default in a periodic stipulated payment. Such options may include an option to surrender the contract for a cash value as determined by the contract, and shall include an option to receive a paid–up annuity if the contract is not surrendered for cash, the amount of such paid–up annuity being determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract.

(d) No individual variable life insurance policy shall be delivered or issued for delivery in this State unless it contains in substance the following provisions or provisions which in the opinion of the Commissioner are more favorable to the holders of such policies:

(1) A provision that there shall be a period of grace of 30 days or one month, within which payment of any premium after the first may be made, during which period of grace the policy shall continue in force, but if a claim arises under the policy during such period of grace before the overdue premiums of the deferred premiums of the current policy year, if any, are paid, the amount of such premiums, together with interest not in excess of 6 per centum per annum, may be deducted from any amount payable under the policy in settlement. The policy may contain a statement of the basis for determining any variation in benefits that may occur as a result of the payment of premium during the period of grace;

(2) A provision that the policy will be reinstated at any time within 2 years from the date of default, unless the cash surrender value has been paid or unless the period of extended insurance has expired, upon the application of the insured and the production of evidence of insurability, including good health, satisfactory to the insurer and the payment of an amount not exceeding the greater of (i) all overdue premiums and the payment of any other indebtedness to the insurer upon said policy with interest at a rate not exceeding 6 per centrum per annum compounded annually, or (ii) 110% of the increase in cash surrender value resulting from reinstatement;

(3) A provision for cash surrender values and paid–up insurance benefits available as nonforfeiture options under the policy in the event of default in a premium payment after premiums have been paid for a specified period. If the policy does not include a table of figures for the options so available, the policy shall provide that the company will furnish at least once in each policy year a statement showing the cash value as of a date no earlier that the prior policy anniversary.

The method of computation of cash values and other nonforfeiture benefits, as described either in the policy or in a statement filed with the Commissioner of the jurisdiction in which the policy is delivered, shall

be in accordance with actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the contract at all times from the date of issue should be equal to the assumed investment increment factor if the contract provides for such a factor, or 3 1/2 if not, with premiums and benefits determined accordingly under the terms of the policy, the resulting cash values and other nonforfeiture benefits would be a least equal to the minimum values required by Sections 10159.1 through 10167 of the Insurance Code for a fixed dollar policy with such premiums and benefits. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, for example, but are not to be limited to, a guarantee under a policy which provides for an assumed investment increment factor that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the contract at all times from the date of issue had been equal to such factor.

(e) Any variable annuity contract delivered or issued for delivery in this State shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder, and may guarantee that expense and/or mortality results shall not adversely affect such dollar amounts. In the case of an individual variable annuity contract under which the expense and mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors shall be stipulated in the contract.

In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(1) The annual net investment increment assumption shall not exceed 5%, except with the approval of the Commissioner;

(2) To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a lower life expectancy at any age, or, if approved by the Commissioner, from another table.

"Expense," as used in this Paragraph, may exclude some or all taxes, as stipulated in the contract.

(f) Any individual variable life insurance policy delivered or issued for delivery in this State shall stipulate the investment increment factor to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder and shall guarantee that expense and mortality results shall not adversely affect such dollar amounts.

(g) The reserve liability for variable contracts shall be established pursuant to the requirements of the Standard Valuation Law (Insurance Code Section 10489.1 through 10489.6) in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

HISTORY

1. Amendment filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30)

§ 2530.1. Disclosure Requirements for Variable Life Contracts.

The following information shall be furnished to an applicant for a contract of variable life insurance prior to execution of the application:

(a) A summary description of the insurance company and its principal activities.

(b) A summary explanation in non–technical terms of the principal variable features of the contract and of the manner in which any variable benefits reflect the investment experience of a separate account.

(c) A brief description of the investment policy for the separate account with respect to such contract.

(d) A list of investments in the separate account as of a date not earlier than the end of the last year for which an annual statement has been filed with the Commissioner of the state of domicile.

(e) Summary financial statements of the insurance company and such separate account based upon the last annual statement filed with such Commissioner, except that for a period of four months after the filing of any annual statement the summary required hereby may be based upon the annual statement, immediately preceding such last annual statement, filed with such Commissioner.

The insurer may include such additional information as it deems appropriate.

A copy of the statement containing the foregoing information shall be filed with such Commissioner prior to any use thereof and shall be subject to disapproval if found to be misleading or inaccurate.

§ 2531. Required Reports.

(a) Any insurer issuing individual variable contracts shall mail to the contractholder at least once in each contract year after the first, at his last address known to the insurer, a statement or statements reporting the investments held in the separate account. The insurer shall submit annually to the Insurance Commissioner a statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners.

(b) Any insurer issuing individual variable contracts shall mail to the contractholder at least once in each contract year after the first, at his last address known to the insurer, a statement reporting as of a date not more than four months previous to the date of mailing: (1) in the case of an annuity contract under which payments have not yet commenced, (i) the number of accumulation units credited to such contract and the dollar value of a unit, or (ii) the value of the contractholder's account; and (2) in the case of a life insurance policy, the dollar amount of the death benefit.

§ 2532. Foreign Insurers.

If the law or regulation in the place of domicile of a foreign insurer or the state of entry or a Canadian insurer provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these regulations, the Commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

§ 2533. Examination of Agents and Other Persons.

(a) Except as permitted by the next Section hereof and Article 16 (commencing with Section 1758.1), Chapter 5, Part 2, Division 1, of the Insurance Code, no person may act as an agent for a life insurer in the transaction of variable contracts unless and until he has received from the Commissioner a license as a Variable Contract Agent pursuant to said Article 16.

(b) A person otherwise properly licensed as a life agent may, without qualifying as a variable contract agent, transact for a life insurer such variable contracts as are exempt from filing under the Securities Act of 1933 and the Investment Company Act of 1940.

§ 2533.1. Agent Licensing Procedures.

(a) A person may obtain a license as a variable contract agent by:

(1) filing a completed application upon the form prescribed by the Commissioner,

(2) paying the statutory fees with such application,

(3) taking and passing the qualifying examination prescribed by the Commissioner, and

(4) submitting written evidence to the Commissioner that he is registered to sell securities in accordance with the rules of the United States Securities and Exchange Commission or the National Association of Securities Dealers, Inc.

(b) The examination will be given in such places and at such times as the Commissioner shall from time to time designate. After filing a completed application for license as a variable contract agent, the applicant shall be notified of the date of the examination for which he is scheduled.

(c) Evidence must be presented that the applicant (1) has complied with the requirements provided in Subsection (a) (4); or (2) is currently registered with the Securities and Exchange Commission or the National Association of Securities Dealers, Inc. as a broker–dealer; or (3) is cur-

rently associated with a broker–dealer or is an NASD–registered representative and has met qualification requirements with respect to such association.

(d) Every applicant applying for license as a variable contract agent shall satisfactorily complete the examination required by Subsection (a)(3) with a grade of at least seventy percent (70%), or shall present evidence of successful completion of a variable contract examination given under the supervision of an insurance department of any State or Territory of the United States during any part of the license year in which the application is filed or the immediately preceding license year.

(e) Examination results will be reported by this Department to any other State Insurance Department requesting confirmation of the examination grade, either upon request of such Department or upon request of the applicant or his appointing company on payment of the fee provided in Section 12973 of the Insurance Code.

(f) Records of the examination grade of each applicant upon an examination administered by this Department, or upon an examination administered by another agency or authority and reported to this Department, will be retained in the file pertaining to said applicant.

(g) Any person licensed in this State as a variable contract agent shall immediately report to the Commissioner (1) any suspension or revocation of his variable contract agent's license or life agent's license in any other State or Territory of the United States; (2) the imposition of any disciplinary sanction (including suspension or expulsion from membership, suspension or revocation of or denial of registration) imposed upon him by any national securities exchange, or national securities association, or any federal, or state or territorial agency with jurisdiction over securities or contracts on a variable basis, any order, judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

(h) The Commissioner may reject any application or suspend or revoke or refuse to renew any variable contract agent's license upon any ground that would bar such applicant or such agent from being licensed to sell life insurance contracts in this State. The rules governing any proceeding relating to the suspension or revocation of a life insurance agent's license shall also govern any proceeding for suspension or revocation of a variable contract agent's license.

(i) Renewal of a variable contract agent's license shall follow the same procedure established for renewal of an agent's license to sell life insurance contracts in this State.

HISTORY

1. Amendment of subsection (c) filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

Article 11.1. Separate Account or Accounts—Variable Life Insurance Contracts

§ 2534. Authority.

The following regulation applicable to variable life insurance policies is promulgated under the authority of Section 10506(h), of the Insurance Code of California, and repeals Ruling No. 177–A to the extent that Ruling No. 177–A was applicable to variable life insurance.

NOTE: Authority cited: Section 10506, Insurance Code.

HISTORY

1. New Article 11.1 (Sections 2534, 2534.1 through 2534.10) filed 12–20–73 as an emergency; effective upon filing (Register 73, No. 51).
2. New Article 11.1 (Sections 2534, 2534.1 through 2534.10) filed 4–19–74 as an emergency; effective upon filing. Certificate of Compliance included (Register 74, No. 16).

§ 2534.1. Definitions.

As used in this regulation:

(a) "Affiliate" of an insurer means any person, directly or indirectly, controlling, controlled by or under common control with such insurer, any person who regularly furnishes investment advice to such insurer with respect to its variable life insurance separate accounts for which a specific fee or commission is charged or any director, officer, partner or employee of any such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

(b) "Agent" means any person, corporation, partnership, or other legal entity which is licensed by this State as a life insurance agent.

(c) "Assumed investment rate" means the rate of investment return which would be required to be credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

(d) "Benefit base" means the amount not less than the amount specified under Section 2534.5(b)(2) specified by the terms of the variable life insurance policy to which the difference between the net investment return and the assumed investment rate is applied in determining the variable benefits of the policy.

(e) "Commissioner" means the Insurance Commissioner of this State.

(f) "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non–management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing more than ten (10) percent of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the Commissioner that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(g) "General account" means all assets of the insurer other than assets in separate accounts established pursuant to Section 10506 of the Insurance Code of this State, whether or not for variable life insurance.

(h) "Incidental insurance benefit" means all insurance benefits in a variable life insurance policy, other than the variable death benefit and the minimum death benefit, including but not limited to accidental death and dismemberment benefits, disability income benefits, guaranteed insurability options, family income or fixed benefit term riders.

(i) "May" is permissive.

(j) "Minimum death benefit" means the amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life insurance policy regardless of the investment performance of the separate account.

(k) "Net investment return" means the rate of investment return actually credited to a variable life insurance policy, after deduction of charges for taxes, investment expenses and mortality and expense guarantees in accordance with the terms of the policy.

(*l*) "Person" means an individual, corporation, partnership, association, trust or fund.

(m) "Separate account" means a separate account established under Section 10506 of the Insurance Code of this State for variable life insurance.

(n) "Shall" is mandatory.

(o) "Variable death benefit" means the amount of the death benefit, other than incidental insurance benefits, payable under a variable life insurance policy dependent on the investment performance of the separate

account which the insurer would have to pay in the absence of the minimum death benefit.

(p) "Variable life insurance policy" means any individual policy which provides for life insurance which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such policy, as provided for in Section 10506 of the Insurance Code of this State.

§ 2534.2. Qualification of Insurer to Issue Variable Life Insurance.

The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this State or which have authority to issue variable life insurance in this State.

(a) Licensing and Approval to Do Business in This State. An insurer shall not deliver or issue for delivery in this State any variable life insurance policy unless:

(1) The insurer is licensed or organized to do a life insurance business in this State;

(2) The state of domicile of such insurer requires that permissible investments be substantially the same as provided in Section 2534.5(c) and that changes in the investment policy of the variable life insurance separate account be regulated in a manner substantially similar to that required under Section 2534.5 for such separate accounts operated by insurers domiciled in this State, and

(3) The insurer has obtained the written approval of the Commissioner for the issuance of variable life insurance policies in this State. The Commissioner shall grant such written approval only after he has found that:

(A) The plan of operation for the issuance of variable life insurance policies is not unsound;

(B) The general character, reputation and experience of the management and those persons or firms proposed to supply consulting, investment, administrative or custodial services to the insurer are such as to reasonably assure competent operation of the variable life insurance business of the insurer in this State, and

(C) The present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such policies is not likely to render its operation hazardous to the public or its policyholders in this State. The Commissioner shall consider, among other things:

1. The history of operation and financial condition of the insurer;

2. The qualifications, fitness, character, responsibility, reputation and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

3. The applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life insurance policies. The state of entry of an alien insurer shall be deemed its state of domicile for this purpose, and

4. If the insurer is a subsidiary of, or is affiliated by common management or ownership with another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meet these standards.

(b) Filing for Approval to Do Business in This State. Before any insurer shall deliver or issue for delivery any variable life insurance policy in this State it must file with this Department the following information for the consideration of the Commissioner in making the determination required by subsection (a) (3) of this Section:

(1) Copies of and a general description of the variable life insurance policies it intends to issue;

(2) A general description of the methods of operation of the variable life insurance business of the insurer, including the names of those persons or firms proposed to supply consulting, investment, administrative or custodial services to the insurer;

(3) With respect to any separate account maintained by an insurer for any variable life insurance policy, a statement of the investment policy the insurer intends to follow for the investment of the assets held in such separate account. The statement shall include a description of the investment objective and orientation intended for the separate account;

(4) A description of any investment advisory services contemplated as required by Section 2534.5(j);

(5) If requested by the Commissioner, a copy of the statutes and regulations of the state of domicile of the insurer under which it is authorized to issue variable life insurance policies, and

(6) If requested by the Commissioner, biographical data with respect to officers and directors of the insurer on the National Association of Insurance Commissioners Uniform Biographical Data Form.

(c) Standards of Suitability. Every insurer seeking approval to enter into the variable life insurance business in this State shall adopt by formal action of its Board of Directors and file with the Commissioner a written statement specifying the Standards of Suitability to be used by the insurer, and applicable to its officers, directors, employees, affiliates, and agents with respect to the suitability of variable life insurance for the applicant. Such Standards of Suitability shall be binding on the insurer and those to whom it refers, and shall specify that no recommendation shall be made to an applicant to purchase a variable life insurance policy and that no variable life insurance policy shall be issued in the absence of reasonable grounds to believe that the purchase of such policy is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or to the agent making the recommendation.

Lapse rates for variable life insurance within the first two policy years, which are significantly higher than both those encountered by the insurer or any affiliate thereof for corresponding fixed benefit life insurance policies and lapse rates of other insurers issuing variable life insurance policies shall be considered in determining whether the guidelines adopted by the insurer are reasonable and also whether the insurer and its agents are engaging, as a general business practice, in the sale of variable life insurance to persons for whom it is unsuitable. For purposes of this subsection, conversions from variable life insurance to fixed benefit life insurance policies pursuant to this regulation, shall not be considered lapses.

(d) Use of Sales Materials. An insurer authorized to transact variable life insurance business in this State shall not use any sales material, advertising material or descriptive literature or other materials of any kind in connection with its variable life insurance business in this State which is false, misleading, deceptive or inaccurate.

(1) All variable life insurance sales material, advertising material and descriptive literature shall be filed 30 business days prior to use with the Commissioner who shall require an insurer to cease the use of any such materials upon finding that any such materials are false, misleading or inaccurate. Revised versions of such materials containing changes of substantial import from versions on file with the Commissioner shall be filed with the Commissioner.

(2) For purposes of this regulation, variable life insurance sales material, advertising material, or descriptive literature shall include but is not limited to:

(A) Printed and published material, audio–visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV and film scripts, billboards, and similar displays for variable life insurance;

(B) Descriptive literature and sales aids of all kinds used to sell variable life insurance by or on behalf of an insurer or any person authorized to sell variable life insurance for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters, and

(C) Prepared sales talks, presentations, and material for use in the sale of variable life insurance by any person authorized to sell variable life insurance.

(e) Requirements Applicable to Contractual Services:

(1) Any contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services which are material with respect to variable life insurance operations shall be in writing and provide that the supplier of such services shall furnish the Commissioner with any information or reports in connection with such services which the Commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with this regulation and any other applicable law or regulations.

(2) Such contract shall be fair and equitable to all parties and not endanger any policyholders of the insurer in this State.

(3) Such contract shall not relieve the insurer from any responsibilities or obligations imposed upon the operations of its variable life insurance business by this regulation or any other law or regulation.

(f) Reports to the Commissioner. Any insurer authorized to transact the business of variable life insurance in this State shall submit to the Commissioner, in addition to any other materials which may be required by this regulation or any other applicable laws or regulations:

(1) An Annual Statement of the business of its variable life insurance separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners, and

(2) Prior to the use in this State any Information Furnished to Applicants as provided for in Section 2534.6, and

(3) Prior to the use in this State the form of any of the Reports to Policyholders as provided for in Section 2534.8, and

(4) Such additional information concerning its variable life insurance operations or its variable life insurance separate accounts as the Commissioner shall deem necessary.

Any material submitted to the Commissioner under this Section shall be disapproved if it is found to be false, misleading, deceptive or inaccurate in any material respect and, if previously distributed, the Commissioner shall require the distribution of an amended report.

(g) Authority of Commissioner to Disapprove. Any material required to be filed with the Commissioner, or approved by him, shall be subject to disapproval if at any time it is found by him not to comply with the standards established by this regulation.

§ 2534.3. Insurance Policy Requirements.

Policy Qualification. The Commissioner shall not approve any variable life insurance form filed pursuant to this regulation unless it conforms to the requirements of this Section.

(a) Filing of Variable Life Insurance Policies. All variable life insurance policies, riders, endorsements, applications and other related documents which are to be attached to and made a part of the policy shall be filed with the Commissioner and approved by him in writing prior to delivery or issuance for delivery in this State.

(1) The procedures and requirements for such filing and approval shall be, to the extent appropriate and not inconsistent with this regulation, the same as those otherwise applicable to other life insurance policies.

(2) The Commissioner may approve variable life insurance policies and related forms which provisions the Commissioner deems to be not less than favorable to the policyholder and the beneficiary than those required by this regulation.

(3) The requirements of subsections (b)(1), (b)(4), and (c)(16) of this Section shall not apply to variable life insurance policies and related forms issued in connection with corporate pension and profit sharing plans and retirement income H.R. 10 pension plans which are exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940 and where applicable other provisions of the Federal securities laws because of their tax qualified status.

(b) Mandatory Policy Benefit and Design Requirements. Variable life insurance policies delivered or issued for delivery in this State shall comply with the following minimum requirements:

(1) Coverage shall be provided for the lifetime of the insured with the mortality and expense risk borne by the insurance company;

(2) Gross premiums for death benefits shall be a level amount for the duration of the premium payment period, but this subparagraph shall not be construed to prohibit temporary or permanent additional premiums for incidental insurance benefits or substandard risks. This subparagraph shall not be deemed to prohibit the use of fixed benefit preliminary term insurance for a period not to exceed 120 days from the date of the application for a variable life insurance policy. The premium rate for such preliminary term insurance shall be stated separately in the application or receipt.

(3) A minimum death benefit is provided in an amount at least equal to the initial face amount of the policy so long as premiums are paid when due (subject to the provisions of subsection (a)(2) of this Section).

(4) The amount payable upon the death of the insured so long as premiums are paid when due (subject to the provisions of subsection (d)(2) of this Section) shall be not less than a minimum multiple of the gross premium payable in that year, exclusive of that portion allocable to any incidental insurance benefit, by a person who meets standard underwriting requirements, as shown in the following table:

Issue Ages	*Multiples*
0–05	80
6–10	71
11–15	63
16–20	55
21–25	47
26–30	40
31–35	33
36–40	27
41–45	21
46–50	15
51–55	13
56–60	11
61–65	9
66–70	8
71 and over	7

(5) The variable death benefit shall reflect the investment experience of the variable life insurance separate account established and maintained by the insurer and that the excess, positive or negative, of the net investment return over the assumed investment rate, as applied to the benefit base of each variable life insurance policy shall be used to provide either:

(A) Fully paid–up variable life insurance providing coverage for the same period as the basic insurance under the policy or fully paid–up fixed benefit term insurance amounts, positive or negative, as the case may be, or a combination thereof, or

(B) Variable life insurance amounts, positive or negative, as the case may be, so that the reserve maintains the same percentage relationship to the variable death benefit as it would have on a corresponding fixed benefit policy.

(6) Each variable life insurance policy shall be credited with the full amount of the net investment return applied to the benefit base.

(7) Changes in variable death benefits of each variable life insurance policy shall be determined at least annually.

(8) The cash value of each variable life insurance policy shall be determined at least monthly. The method of computation of cash values and other non–forfeiture benefits, as described either in the policy or in a statement filed with the Commissioner of the state in which the policy is delivered, or issued for delivery, shall be in accordance with the actuarial procedures that recognize the variable nature of the policy. The method of computation must be such that, if the net investment return credited to the policy at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the policy, then the resulting cash values and other non–forfeiture benefits must be at least equal to the minimum values required by Sections 10159.1 through 10167 of the Insurance Code of this State (Standard Non–Forfeiture Law) for a fixed benefit policy with such premiums and benefits. The assumed investment rate shall not exceed the maximum interest rate permitted under the Standard Non–Forfeiture Law of this State. The method of computation may disregard incidental minimum guarantees as to the dollar amount payable. Incidental mini-

mum guarantees, include, for example, but are not to be limited to, a guarantee that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the policy at all times from the date of issue had been equal to the assumed investment rate.

(9) The computation of values required for each variable life insurance policy may be based upon such reasonable and necessary approximations as are acceptable to the Commissioner.

(10) (A) If the gross premiums for any variable life insurance policy delivered or issued for delivery in this State produce an excess of 1. over 2. as defined in (B) below, the present value as of the date of issue of the adjusted premiums used in determining the minimum cash values required by subsection (b)(8) of this Section shall be decreased by such excess by decreasing each adjusted premium by a uniform percentage.

(B) The excess of 1. over 2. referred to in (A) above shall be determined as of the date of issuance on the basis of the mortality table and maximum rate of interest permitted by Sections 10159.1 through 10167 of the Insurance Code of this State (Standard Non–Forfeiture Law), and

1. Is the present value of the gross premiums for the policy, decreased by one dollar per thousand of equivalent uniform account for policies with an equivalent uniform amount of less than ten thousand, payable on an annual basis (exclusive of those portions of the gross premiums allocable to any incidental insurance benefits) by a person who meets standard underwriting requirements, and

2. Is the product of (1) times (2) where (1) is the present value of the maximum premium rates per thousand of insurance shown below payable at the beginning of each policy year to attained age 65 of the insured for issue ages below age 51, for fifteen years for issue ages 51 to 70 and for life for issue ages above age 70 and (2) is the ratio of (i) the present value of the benefits under the policy to (ii) the present value of an insurance of one thousand for the whole of life.

TABLE OF RATES

Age at Issue	*Premium Rate*	*Age at Issue*	*Premium Rate*
0	$11.50	41	$38.65
1	11.60	42	40.45
2	11.76	43	42.51
3	11.97	44	44.89
4	12.22	45	47.62
5	12.50	46	50.71
6	12.80	47	54.17
7	13.11	48	58.00
8	13.43	49	62.18
9	13.75	50	66.67
10	14.08	51	68.58
11	14.42	52	70.54
12	14.77	53	72.57
13	15.13	54	74.69
14	15.49	55	76.92
15	15.87	56	79.29
16	16.27	57	81.84
17	16.70	58	84.61
18	17.16	59	87.63
19	17.65	60	90.91
20	18.18	61	94.45
21	18.74	62	98.25
22	19.34	63	102.31
23	19.97	64	106.61
24	20.62	65	111.11
25	21.28	66	115.48
26	21.95	67	119.39
27	22.64	68	122.51
28	23.37	69	124.50
29	24.15	70	125.00
30	25.00	71	118.86
31	25.92	72	123.96
32	26.91	73	129.66
33	27.97	74	135.96
34	29.10	75	142.86
35	30.30	76	150.36
36	31.55	77	158.46
37	32.84	78	167.16
38	34.17	79	176.46
39	35.56	80	186.36
40	37.04		

(C) For purposes of this subsection, any portion of the premium set aside to support a guarantee that any surrender value shall not be less than a specified amount or for any other benefit that the Commissioner shall deem to be excludable, shall not be included.

(c) Mandatory Policy Provisions. Every variable life insurance policy filed for approval in this State shall contain at least the following:

(1) The cover page or pages corresponding to the cover page of each such policy shall contain:

(A) A prominent statement in either contrasting color or in boldface type at least four points larger than the type size of the largest type used in the text of any provision on that page, that the death benefit may be variable or fixed under specified conditions;

(B) A prominent statement in either contrasting color or in boldface type at least four points larger than the type size of the largest type size used in the text of any provision on that page, that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees);

(C) A statement that the minimum death benefit will be at least equal to the initial face amount at the date of issue if premiums are paid when due and if there are no outstanding policy loans, partial withdrawals, or partial surrenders;

(D) The rule, or a reference to the policy provision, which describes the method for determining the variable amount of insurance payable at death;

(E) A captioned provision which provides that the policyholder may return the variable life insurance policy within 45 days of the date of the execution of the application or within 10 days of receipt of the policy by the policyholder, whichever is later, and receive a refund of all premium payments for such policy, and

(F) Such other items as are currently required for fixed benefit life insurance policies and which are not inconsistent with this regulation.

(2) A provision for a grace period of not less than thirty–one days from the premium due date which shall provide that where the premium is paid within the grace period, policy values will be the same, except for the deduction of any overdue premium, as if the premium were paid on or before the due date;

(3) A provision that the policy will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(A) All overdue premiums and any other indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding 6% per annum compounded annually, or

(B) 110% of the increase in cash surrender value resulting from reinstatement.

(4) A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the policy.

(5) A provision designating the separate account to be used and stating that:

(A) Such separate account shall be used to fund only variable life insurance benefits, except to the extent permitted by subsection (e)(3)(F) of this Section;

(B) The assets of such separate account shall be available to cover liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life insurance policies supported by the separate account, and

(C) The assets of such separate account shall be valued at least as often as any policy benefits vary but at least monthly.

(6) The policy shall also contain a provision that any time during the first eighteen months of the variable life insurance policy the owner may exchange the policy for a policy of permanent fixed benefits insurance for the same initial amount of insurance as the variable life insurance policy provided that the new policy:

(A) Shall bear the same date of issue and age at issue as the original variable life insurance policy;

(B) Is issued on any plan of permanent insurance offered by the insurer or an affiliate on the date of issue of the variable life insurance policy and premium rates in effect on that date for the same class of insurance.

(C) Include such riders and incidental insurance benefits as were included in the original policy if such riders and incidental insurance benefits are issued with the fixed benefit policy. If the exchange results in an increase or decrease in cash value such increase or decrease will be payable to the insurer or the insured as the case may be.

(D) The insurer must apply as an advance premium on the new policy any excess of the accrued premium on the original variable life insurance policy from the date of issue to the date of request for exchange over the corresponding accrued premium on the new fixed benefit policy except that any portion on such excess which is less than a regular mode premium on the new policy may either be applied as an advance premium or refunded in cash at the option of the insurer.

(E) The insurer shall not require evidence of insurability for this exchange.

(7) A provision that the policy and any papers attached thereto by the insurer, including the application if attached, constitute the entire insurance contract;

(8) A designation of the officers of the insurer who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his behalf, shall be considered as representations and not warranties;

(9) An identification of the owner of the insurance contract;

(10) A provision setting forth conditions or requirements as to the designation, or change of designation of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation;

(11) A statement of any conditions or requirements concerning the assignment of the policy;

(12) A description of any adjustments in policy values to be made in the event of misstatement of age or sex of the insured;

(13) A provision that the policy shall be incontestable by the insurer after it has been in force for two years during the lifetime of the insured;

(14) A provision stating that the investment policy of the separate account shall not be changed without the approval of the Insurance Commissioner of the state of domicile of the insurer, and that the approval process is on file with the Commissioner of this State;

(15) A provision that payment of variable death benefits in excess of the minimum death benefits, cash values, policy loans or partial withdrawals (except when used to pay premiums) or partial surrenders may be deferred:

(A) For up to six months from the date of request, or

(B) For any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical.

(16) Settlement options shall be provided on a fixed basis only;

(17) A description of the basis for computing the cash surrender value under the policy shall be included. Such surrender value may be expressed as either:

(A) A schedule of cash value amounts per one thousand dollars of variable death benefit at each attained age or policy year for at least 20 years from issue, or for the premium paying period, if less than 20 years, or

(B) One cash value schedule as described in paragraph (A) for the death benefit, or for each one thousand dollars of death benefit, which would be in effect if the net investment return is always equal to the assumed investment rate and a second schedule applicable to any adjustments to the death benefit (disregarding the minimum death benefit guarantee and term insurance amounts) if the net investment return does not equal the assumed investment rate at each age for at least 20 years from issue, or for the premium paying period if it is less than 20 years.

(18) Premiums for incidental insurance benefits shall be stated separately.

(19) Any other policy provisions required by this regulation.

(20) Such other items as are currently required for fixed benefit life insurance policies and are not inconsistent with this regulation.

(d) Non–Forfeiture, Partial Withdrawal, Policy Loan and Partial Surrender Provisions. Every variable life insurance policy delivered or issued for delivery in this State shall contain provisions which are not less favorable to the policyholder than the following:

(1) A provision for non–forfeiture insurance benefits so that at least one such benefit is offered on a fixed basis from the due date of the premium in default.

(A) Variable extended term insurance may not be offered.

(B) A given non–forfeiture insurance benefit need not be offered on both a fixed and a variable basis.

(C) The insurer may establish a reasonable minimum cash surrender value below which any such non–forfeiture insurance options will not be available.

(2) A provision for policy loans (which may at the option of the insurer be entitled and referred to as a partial withdrawal provision) not less favorable to the policyholder than the following:

(A) Up to 75%, but if the loan is made from the general account, not more than 90% of the policy's cash value may be borrowed;

(B) The amount borrowed, or any repayment thereof, shall not affect the amount of the premium payable under the policy;

(C) The amount borrowed shall bear interest at a rate not to exceed 6% per year compounded annually;

(D) The proceeds payable on death after the exercise of the policy loan provision shall equal the greater of the minimum death benefit or the variable death benefit, less the indebtedness outstanding;

(E) Any indebtedness shall be deducted from the cash value upon surrender or in determining any non–forfeiture benefit;

(F) Whenever the indebtedness exceeds the cash value, the insurer shall give notice of intent to cancel the policy if the excess indebtedness is not repaid within thirty–one days after the date of mailing of such notice;

(G) The policy may provide that if, at any time, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the policyholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110% of the corresponding increase in cash value and by furnishing such evidence of insurability as the insurer may request;

(H) The policy may specify a reasonable minimum amount which may be borrowed at any time but such minimum shall not apply to any automatic premium loan provision;

(I) No policy loan provision is required if the policy is under the extended term non–forfeiture insurance benefit;

(J) In addition to the foregoing the policy may contain a partial surrender provision; however, any such provision shall provide that the policyholder may request part of the cash value and both the variable and minimum death benefits will be reduced in proportion to the percentage of the cash value received by the policyholder and the premium for the remaining amount of insurance will also be reduced to the appropriate rates for the reduced amount of insurance. The policy may provide that a partial surrender provision shall not require the insurer to reduce the amount of the minimum death benefit to less than the lowest amount of minimum death benefit which would have been issued to the insured under the insurance plans of the insurer at the time the policy was issued. The policy must clearly provide that the policyholder has the option of electing to ex-

ercise the cash value privileges of the policy loan or partial withdrawal provision rather than the partial surrender provision.

(K) All policy loan, partial withdrawal or partial surrender provisions shall be constructed so that variable life insurance policy–holders who have not exercised such provision are not disadvantaged by the exercise thereof.

(L) Monies paid to the policyholders upon the exercise of any policy loan, partial withdrawal or partial surrender provision shall be withdrawn from the separate account and shall be returned to the separate account upon repayment except that a stock insurer may provide the monies for policy loans from the general account.

(e) Other Policy Provisions. The following provisions may in substance be included in a variable life insurance policy or related form delivered or issued for delivery in this State:

(1) An exclusion for suicide within two years of the policy issue date;

(2) Incidental insurance benefits may be offered on a fixed basis only;

(3) Policies issued on a participating basis shall offer to pay dividend amounts in cash. In addition such policies may offer the following dividend options:

(A) The amount of the dividend may be credited against premium payments;

(B) The amount of the dividend may be applied to provide paid–up amounts of additional fixed benefit whole life insurance;

(C) The amount of the dividend may be applied to provide paid–up amounts of additional variable life insurance;

(D) The amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(E) The amount of the dividend may be applied to provide paid–up amounts of fixed benefit one–year term insurance;

(F) The amount of the dividend may be deposited as a variable deposit in the separate account in the case of variable life insurance policies exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940 because of their tax qualified status.

(4) A provision allowing the policyholder to elect in writing in the application for the policy or thereafter an automatic premium loan on a basis not less favorable than that required of policy loans or partial withdrawals under subsection (d) of this Section, except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed.

§ 2534.4. Reserve Liabilities for Variable Life Insurance.

(a) Reserve liabilities for variable life insurance policies shall be established under Section 10489.1 et seq. of the California Insurance Code (Standard Valuation Law) in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(b) Reserve liabilities for the guaranteed minimum death benefit shall be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and shall be maintained in the general account of the insurer and shall be not less than the greater of the following minimum reserves:

(1) The aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life insurance contract, assuming an immediate one–third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the assumed investment rate, or

(2) The aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall equal the "residue," as described in subparagraph (A), of the prior year's "attained age level" reserve on the contract, with any such "residue" increased or decreased by a payment computed on an attained age basis as described in subparagraph (B) below.

(A) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract shall not be less than zero and shall be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence shall be based on the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death payments over the year;

(B) The payment referred to in subsection (b)(2) of this Section shall be computed so that the present value of a level payment of that amount each year over the future premium paying period of the contract is equal to (A) minus (B) minus (C), where (A) is the present value of the future guaranteed minimum death benefits, (B) is the present value of the future death benefits that would be payable in the absence of such guarantee and (C) is any "residue," as described in subparagraph (A), of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid–up, the payment shall equal (A) minus (B) minus (C). The amounts of future death benefits referred to in (B) shall be computed assuming a net investment return of the separate account which may differ from the assumed investment rate and/or the valuation interest rate but in no event may exceed the maximum interest rate permitted for the valuation of life insurance contracts.

(3) The valuation interest rate and mortality table used in computing the two minimum reserves described in (1) and (2) above shall conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the company may employ suitable approximations and estimates, including but not limited to groupings and averages.

(c) Reserve liabilities for all fixed incidental insurance benefits shall be maintained in the general account in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

§ 2534.5. Separate Accounts.

The following requirements apply to the establishment and administration of variable life insurance separate accounts:

(a) Establishment and Administration of Separate Accounts. An insurer issuing variable life insurance in this State shall establish one or more separate accounts pursuant to Section 10506 of the Insurance Code of this State.

(1) If no law or other regulation provides for the custody of separate account assets and if the insurer itself is not the custodian of such assets, all contracts for such custody shall be in writing and the Commissioner of the insurer's state of domicile shall approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

(2) An insurer shall not, without the prior written approval of the Commissioner, employ in any material connection with the handling of separate account assets any person who:

(A) Within the last ten years has been convicted of any felony or a misdemeanor arising out of such persons conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of Sections 1341, 1342, or 1343 of Title 18, United States Code, or

(B) Within the last ten years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit or knowing misrepresentation, or

(C) Within the last ten years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state securities laws involving fraud, deceit or knowing misrepresentation.

(3) All persons with access to the cash, securities or other assets of the separate account shall be under bond in an amount of not less than the following amounts for each separate account:

TOTAL ASSETS		*MINIMUM AMOUNT OF BOND*
Under $100,000		$10,000
More Than:	But Not More Than:	
$100,000	$600,000	$10,000 plus 4% of assets over $100,000
600,000	1,200,000	$30,000 plus 3–1/3% of assets over $600,000
1,200,000	3,200,000	$50,000 plus 2–1/2% of assets over $1,200,000
3,200,000	4,450,000	$100,000 plus 2% of assets over $3,200,000
4,450,000	6,450,000	$125,000 plus 1–1/4% of assets over $4,450,000
6,450,000	90,450,000	$150,000 plus 5/8% of assets over $6,450,000
90,450,000	350,450,000	$675,000 plus 3/8% of assets over $90,450,000
350,450,000	1,070,450,000	$1,625,000 plus 3/16% of assets over $350,450,000
1,070,450,000	———	$3,075,000 plus 3/32% of assets over $1,070,450,000 until total bond equals $5,000,000

(4) If an insurer establishes more than one separate account for variable life insurance, justification for the establishment of each additional separate account shall also be filed with the Commissioner and shall be subject to his approval. The creation of additional separate accounts to avoid lower maximum charges against the separate account is prohibited.

(5) The assets of such separate accounts established for variable life insurance policies shall be valued at least as often as variable benefits are determined but in any event at least monthly.

(6) The same separate account shall not be used to fund both variable life insurance policies which are exempt pursuant to Section 3(c)(11) of the Investment Company Act of 1940 because of their tax qualified status and other variable life insurance policies not so exempt.

(7) Except as provided in Section 2534.3(e)(3)(F), variable life insurance separate accounts shall not be used for variable annuities or for the investment of funds corresponding to dividend accumulations or other policyholder liabilities not involving life contingencies.

(b) Amounts in the Separate Account.

(1) The insurer shall maintain in each variable life insurance separate account assets with a fair market value at least equal to the greater of the valuation reserves for the variable portion of the variable life insurance policies or the benefit base for such policies.

(2) The benefit base of any variable life insurance policy as of the beginning of any valuation period shall not be less than the sum of the following factors after deducting amounts of any indebtedness pursuant to Section 2534.3(d)(2):

(A) The valuation net premium for such period based upon the initial amount insured, and

(B) The valuation terminal reserve at the end of the immediately preceding valuation period based upon the amount insured at the end of such period less the discounted cost of term insurance for the next period based upon tabular mortality and the interest rate used for such valuation reserves.

(3) In lieu of the minimum benefit base requirement specified above, an insurer may otherwise qualify under this Section if it can be demonstrated, to the satisfaction of the Commissioner, that the policy benefits obtained over a 20–year period from the date of issue by the use of the insurer's benefit base are at least substantially equivalent in value to the benefits obtained by the use of the minimum benefit base specified above. The Commissioner may specify the range of net investment return to be used in this demonstration.

(4) Notwithstanding the actual reserve basis used for policies that do not meet standard underwriting requirements, the benefit base for such policies may be the same as for corresponding policies which do meet standard underwriting requirements.

(c) Investments by the Separate Account.

(1) No sale, exchange or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(A) In case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made, and

(B) Such transfer, whether into or from a separate account, is made by a transfer of cash, but other assets may be transferred if approved by the Commissioner in advance.

(2) Assets allocated to a variable life insurance separate account shall be held in cash or investments having a reasonably ascertainable market price. For the purposes of this subsection, only the following shall be considered "investments having a reasonably ascertainable market price":

(A) Liens in favor of the insurer against separate account policy reserves resulting from use by policyholders of cash values;

(B) Securities listed and traded on the New York Stock Exchange, the American Stock Exchange or regional stock exchanges or successors to such exchanges having the same or similar qualifications;

(C) Securities listed on the NASDAQ System;

(D) Shares of an investment company registered pursuant to the Investment Company Act of 1940. Where such an investment company issues book shares in lieu of share certificates, such book shares shall be deemed to be adequate evidence of ownership;

(E) Obligations of or guaranteed by the United States government, the Canadian government, any state, or municipality or governmental subdivision of a state;

(F) Commercial paper issued by business corporations when the total of such paper issued by the corporation does not exceed in value a guaranteed short line of credit by a bank.

(G) Certificates of deposit issued by financial institutions the deposits of which are insured by the FDIC or FSLIC, and

(H) New bond or debt issues which may reasonably be expected to be listed on an exchange regulated by the Securities Exchange Act of 1934.

(3) Notwithstanding any other provision of law or the provisions of paragraph (2) above, assets allocated to a variable life insurance separate account shall not be invested in:

(A) Commodities or commodity contracts;

(B) Put and call options or combinations of such options;

(C) Short sales;

(D) Purchases on margins;

(E) Letter or restricted stock;

(F) Units or other evidences of ownership of a separate account of another insurer, except those registered under the Investment Company Act of 1940, or

(G) Real estate other than shares of a real estate investment trust listed as described in paragraph (2) above.

(d) Limitations on Ownership.

(1) A variable life insurance separate account shall not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such separate account in such security valued as required by this regulation, would exceed 10% of the value of the assets of the separate account. The Commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this State.

(2) No separate account shall purchase or otherwise acquire the voting securities of any issuer if as a result of such acquisition the insurer and its separate accounts, in the aggregate, will own more than 10% of the to-

tal issued and outstanding voting securities of such issuer. The Commissioner may waive this limitation in writing if he believes such waiver will not render the operation of the separate account hazardous to the public or the policyholders in this State or jeopardize the independent operation of the issuer of such securities.

(3) The percentage limitation specified in paragraph (1) above, shall not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to the Investment Company Act of 1940 if the investments and investment policies of such investment companies comply substantially with the provisions of subsection (c) of this Section and other applicable portions of this regulation.

(e) Valuation of Assets of a Variable Life Insurance Separate Account.

(1) Investments of the separate account shall be valued at their market value on the date of valuation.

(A) Market value for investments traded on the recognized exchanges means the last reported sale price on the date of valuation. If there has been no sale on that date, the market value means the last report bid quotation on the date of valuation.

(B) Market value for investments listed on the NASDAQ System means the last representative bid quotation on the valuation date. If an investment ceases to be listed but continues to be traded over the counter, it shall be valued at the lowest bid quotation as it appears on the National Quotation Bureau sheets.

(C) If the valuation date referred to in subparagraphs (A) and (B) above is a day when the exchange or the NASDAQ System is not open for business, the valuation date shall be the last date when the exchange or the NASDAQ System was open for business.

(2) If an investment ceases to be traded, it shall be valued at fair value as determined in good faith by or at the direction of the Board of Directors of the insurer but not in excess of the last reported bid quotation. Within thirty days notification of cessation of trading of any investment shall be reported by the insurer to the Insurance Commissioner of the state of domicile of the insurer. Such Commissioner shall within a reasonable period of time determine the method of valuation or disposition of such investment.

(f) Separate Account Investment Policy.

(1) The investment policy of a separate account operated by a domestic insurer filed under Section 2534.2(b)(3) shall not be changed without the approval of the Commissioner.

(2) With respect to changes of investment policy for which the Commissioner must give his approval, the following regulations shall apply:

(A) Such approval shall be deemed to be given sixty days after the date the request for approval was filed with the Commissioner, unless he notifies the insurer before the end of such sixty day period of his determination that the proposed change is a material change in the investment policy.

(B) If the change is deemed material by the Commissioner, he shall approve such change only if he determines, after a public hearing, that the change does not appear to be detrimental to the interest of the policyholders of the insurer.

(C) At least thirty days prior to any public hearing under subparagraph (B), the insurer shall mail a notice to each policyholder and to the Insurance Commissioner of each state in which the affected variable life insurance policies are being sold. Such notice shall describe the proposed change in investment policy, list the reasons therefor, designate the date and place of the public hearing, inform the policyholder of the procedures to be followed in commenting on the change, and describe the conduct of the meeting. Any such notice shall be in a form approved by the Commissioner.

(D) Within sixty days after such public hearing the Commissioner must approve or deny the proposed change in investment policy.

(E) Should any policyholder object to the proposed change and the change is allowed by the Commissioner, the objecting policyholder shall be given the option within sixty days of notification to the policyholder of the approval by the Commissioner of such change, of converting, without evidence of insurability, under one of the following options, to a fixed benefit life insurance policy issued by the insurer or an affiliate:

(1) As of the original issue age to a permanent form of life insurance, based on the insurer's premium rates for fixed life insurance at the original issue age, for an amount of insurance not exceeding the death benefit of the variable life insurance policy on the date of conversion. If the cash value of the variable life insurance policy exceeds the cash value of the fixed life insurance policy, the difference shall be paid to the policyholder. If the cash value of the fixed life insurance policy exceeds the cash value of the variable life insurance policy, the difference shall be paid by the policyholder;

(2) As of the attained age to a substantially comparable permanent form of life insurance for an amount of insurance not exceeding the excess of the death benefit of the variable life insurance policy over:

(i) Its cash value on the date of conversion if the withdrawing policyholder elects the cash surrender option, or

(ii) The death benefit payable under any paid–up insurance option if the withdrawing policyholder elects such option.

(g) Charges Against a Variable Life Insurance Separate Account.

(1) The insurer may deduct only the following from the separate account:

(A) Taxes or reserves for taxes attributable to investment gains and income of the separate account;

(B) Actual cost of reasonable brokerage fees and similar direct acquisition and sales costs incurred in the purchase or sale of separate account assets;

(C) Actuarially determined costs of insurance (tabular costs) and the release of reserves on the termination or partial surrender of the variable life insurance policy;

(D) Charges for investment management expenses, including internal costs attributable to the investment management of assets of the separate account, not exceeding the following percentages, on an annual basis, of the average net asset value of the separate account as of the dates of valuation under subsection (a)(5) of this Section:

1. .75% of that portion of separate account assets valued under $75,000,000; and;
2. .50% of that portion of separate account assets valued at or in excess of $75,000,000 but less than $150,000,000; and;
3. .40% of that portion of separate account assets valued at or in excess of $150,000,000 but less than $400,000,000; and;
4. .35% of that portion of separate account assets valued at or in excess of $400,000,000 but less than $800,000,000; and;
5. .30% of that portion of separate account assets valued at or in excess of $800,000,000.

(E) A charge, at a rate specified in the policy, not to exceed .50% per year of the average net asset value of the separate account as of the dates of valuation under subsection (a)(5) of this Section for mortality and expense guarantees.

(2) Any charges against the separate account made by either an affiliate of the insurer or an unaffiliated fund shall be considered part of the charges limited by paragraphs (1)(d) and (1)(E) of subsection (g) above. Any charge against the separate account, excluding taxes, shall not vary in accordance with the difference between the investment performance of the separate account and any index of securities prices or other measure of investment performance.

(h) Standards of Conduct. Every insurer seeking approval to enter into the variable life insurance business in this State shall adopt by formal action of its Board of Directors and file with the Commissioner, a written statement specifying the Standards of Conduct of the insurer, its officers, directors, employees, and affiliates with respect to investments of variable life insurance separate accounts and variable life insurance operations. Such Standards of Conduct shall be binding on the insurer and those to whom it refers, and must contain at a minimum the items contained in subsection (i)(2) of this Section.

(i) Conflicts of Interest.

(1) Rules under any provision of the Insurance Code of this State or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee or other similar body. No officer or director of such company nor any member of any managing committee or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account. The Board of Directors of the insurer shall be responsible for all acts concerning the separate account.

(2) Unless otherwise approved in writing by the Commissioner in advance of the transaction, with respect to variable life insurance separate accounts, an insurer or affiliate thereof shall not:

(A) Sell to or purchase from any such separate account established by the insurer any securities or other property, other than variable life insurance policies;

(B) Purchase or allow to be purchased for any such separate account any securities of which the insurer or an affiliate is the issuer;

(C) Accept any compensation, other than a regular salary or wages from such insurer or affiliate, for the sale or purchase of securities to or from any such separate account other than as provided in subsection (i)(3)(C) of this Section;

(D) Engage in any joint transaction, participation or common undertaking whereby such insurer or an affiliate participates with such a separate account in any transaction in which an insurer or any of its affiliates obtains an advantage in the price or quality of the item purchased, in the service received, or in the cost of such service and the insurer or any of its other affiliates is disadvantaged in any of these respects by the same transaction;

(E) Borrow money or securities from any such separate account other than under a policy loan provision.

(3) No provision of this regulation shall be construed to prohibit:

(A) The investment of separate account assets in securities issued by one or more investment companies pursuant to the Investment Company Act of 1940 which is sponsored or managed by the insurer or an affiliate, and the payment of investment management or advisory fees on such assets;

(B) The combination of orders for the purchase or sale of securities for the insurer, an affiliate thereof, any separate account, or any one or more of them, which is for their mutual benefit or convenience so long as any securities so purchased or the proceeds of any sale thereof are allocated among the participants on some predetermined basis expressed in writing which is designed to assure the equitable treatment of all participants;

(C) An insurer or an affiliate to act as a broker or dealer in connection with the sale of securities to or by such separate account; however, any commission, fee or other remuneration charged therefor shall not exceed the minimum broker's commission established for any such transaction by any national securities exchange through which such transaction could be effected or where such charges prevailing, in the ordinary course of business in the community where such transaction is effected;

(D) The rendering of investment management or investment advisory services by an insurer or affiliate, for a fee, subject to the provisions of this regulation.

(4) The Commissioner may, upon the written request of an insurer or an affiliate, approve a particular transaction or series of proposed transactions which would otherwise be prohibited under paragraph (2) if he determines such transaction is not unfair or inequitable to persons affected under the circumstances of such transactions.

(j) Investment Advisory Services to a Separate Account.

(1) An insurer shall not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance policies unless:

(A) The person providing such advice is registered as an investment advisor under the Investment Advisors Act of 1940, or

(B) The insurer has filed with the Commissioner and continues to file annually the following information and statements concerning the proposed advisor:

1. The name and form of organization, state of organization, and its principal place of business;

2. The names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, of such individual;

3. A written Standard of Conduct complying in substance with the requirements of subsection (h) of this Section which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

4. A statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(i) Has, within the last ten years, been convicted or has acknowledged violation of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director of an insurance company, a bank, an insurance agent, a securities broker, or an investment advisor; involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of Sections 1341, 1342, or 1343 of Title 18 of the United States Code;

(ii) Has been permanently or temporarily enjoined by order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii) Has been found by federal or state regulatory authorities to have willfully violated or has acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under any such laws, or

(iv) Has been censured, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended or been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities, and

(C) Such investment advisory contract shall be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than sixty days written notice to the investment advisor.

(2) The Commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if he deems continued operation thereunder to be hazardous to the public or the insurance company's policyholders.

§ 2534.6. Information Furnished to Applicants.

An insurer delivering or issuing for delivery in this State any variable life insurance policies shall deliver to the applicant for the policy, and obtain a written acknowledgement of receipt from such applicant coincident with or prior to the execution of the application, the following information. The requirements of this Section shall be deemed to have been satisfied by the delivery to the applicant of a prospectus included in a registration statement which satisfies the requirements of the Securities Act of 1933 and which was declared effective by the Securities and Exchange Commission to the extent that the prospectus contains the information required by this Section.

(a) A summary explanation, in non–technical terms, of the principal features of the policy, including a description of the manner in which the variable benefits will reflect the investment experience of the separate account and the factors which affect such variation;

(b) A statement of the investment policy of the separate account, including:

(1) A description of the investment objective and orientation intended for the separate account and the principal types of investments intended to be made, and

(2) Any restriction or limitations on the manner in which the operations of the separate account are intended to be conducted;

(c) A statement of the net investment return of the separate account for each of the last ten years for which the separate account was in existence;

(d) A statement describing, as an approximate percentage of an annual gross premium for each year and for the life of the policy, all commission or equivalent payments to be paid to all agents or other persons as a result of the proposed sale for each year of the policy for which such payments are to be made. As used in this subsection, "commissions" mean all monies and other valuable consideration, including but not limited to prizes, bonuses paid directly or indirectly to, for, or on behalf of the selling agent as compensation for services in the sale of variable life insurance;

(e) A statement of the annual taxes, brokerage fees, and similar costs, and the charges expressed as an annual percentage, levied against the separate account during the previous year;

(f) A summary of the method to be used in valuing assets held by the separate account;

(g) A summary of the federal income tax liabilities of the policy applicable to the insured, the policy owner, and the beneficiary;

(h) If the applicant is furnished illustrations of benefits payable under any variable life insurance contract, such illustrations shall be prepared by the insurer and shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided that nothing contained herein prohibits use of hypothetical assumed rates of return to illustrate possible levels of benefits, and that it is made clear that such assumed rates are hypothetical only;

(i) A prominent statement either in contrasting color or in boldface type at least four points larger than the type size of the largest type used in the text of any provision on the page providing in substance the following information:

The purpose of this variable life insurance policy is to provide insurance protection for the beneficiary named therein.

No claim is made that this variable life insurance policy is in any way similar or comparable to a systematic investment plan of a mutual fund.

§ 2534.7. Applications.

The application for a variable life insurance policy shall contain:

(a) A prominent statement that the death benefit may be variable or fixed under specified conditions;

(b) A prominent statement that cash values may increase or decrease in accordance with the experience of the separate account (subject to any specified minimum guarantees), and

(c) Questions designed to elicit information which enables the insurer to determine the suitability of variable life insurance for the applicant.

§ 2534.8. Reports to Policyholders.

Any insurer delivering or issuing for delivery in this State any variable life insurance policies shall mail to each variable life insurance policyholder at his or her last known address the following reports:

(a) Within thirty days after each anniversary of the policy, a statement or statements of the cash surrender value, death benefit, any partial withdrawal or policy loan, any interest charge, and any optional payments allowed pursuant to Section 2534.3(d) under the policy computed as of the policy anniversary date. Provided however that such statement may be furnished within thirty days after a specified date in each policy year so long as the information contained therein is computed as of a date not more than forty–five days prior to the mailing of such notice. This statement shall state in contrasting color or distinctive type that, in accordance with the investment experience of the separate account, the cash values and the variable death benefit may increase or decrease, and shall prominently identify any value described therein which may be recomputed prior to the next statement required by this Section. If the policy guarantees that the variable death benefit on the next policy anniversary date will not be less than the variable death benefit specified in such statement, the statement shall be modified to so indicate.

(b) Annually, a statement or statements including:

(1) A summary of the financial statement of the separate account based on the Annual Statement last filed with the Commissioner;

(2) The net investment return of the separate account for the last year and, for each year after the first, a comparison of the investment rate of the separate account during the last year with the investment rate during prior years, up to a total of five years when available;

(3) A list of investments held by the separate account as of a date not earlier than the end of the last year for which an Annual Statement was filed with the Commissioner;

(4) Any charges, taxes, and brokerage fees determined on an accrual basis payable by the separate account during the previous year, each expressed as a dollar amount and a percentage, and the total expressed as a dollar amount and as a percentage of the assets of the separate account;

(5) A statement of the portfolio turnover rate as defined herein during the preceding fiscal year of investments allocated to the separate account:

(A) The rate shall be calculated by dividing (A) the lesser of purchases or sales of portfolio securities for the particular fiscal year by (B) the monthly average of the value of the portfolio securities owned by the separate account during the particular fiscal year. Such monthly average shall be calculated by totaling the values of the portfolio securities as of the beginning and end of the first month of the particular fiscal year and as of the end of each of the succeeding eleven months, and dividing the sum by 13, except that the average value of securities for which market quotations are not available may be based upon the value of such securities as of the end of the preceding fiscal quarters.

(B) For the purposes of this item, there shall be excluded from both the numerator and the denominator all U. S. Government securities (short–term and long–term) and all other securities whose maturities at the time of acquisition were one year or less. Purchases shall include any cash paid upon the conversion of one portfolio security into another. Purchases shall also include the cost of rights or warrants purchased. Sales shall include the net proceeds of the sale of rights or warrants. Sales shall also include the net proceeds of redemptions of portfolio securities by call or maturity.

(C) The insurer shall show, in addition to the calculated portfolio turnover rate, both the amount of the purchases and the amount of the sales (calculated as prescribed in (B) above) and the monthly average (but not the individual monthly figures) of the value of the portfolio securities owned by the separate account during the fiscal year.

(D) The insurer may if it wishes make any statement or explanation with respect to any significant variations in the portfolio turnover rate during the three fiscal years next preceding;

(6) A statement of any change, since the last report, in the investment objective and orientation of the separate account, in any investment restriction or material quantitative or qualitative investment requirement applicable to the separate account, or in the investment advisor of the separate account;

(7) The name of each broker or dealer handling portfolio transactions on behalf of the separate account in which the insurer or an affiliate has any material, direct or indirect, interest and the nature of such transactions and the amount of compensation received by each such broker or dealer from business originating with the separate account during the preceding fiscal year;

(8) The names and principal occupations of each principal executive officer and each director of the insurer, and

(9) The names of all parents of the insurer and the basis of control of the insurer, and the name of any person who is known to own, of record or beneficially, 10% or more of the outstanding voting securities of the company.

§ 2534.9. Qualification of Agents for the Sale of Variable Life Insurance.

(a) Qualification to Sell Variable Life Insurance.

(1) No person may sell or offer for sale in this State any variable life insurance policy unless such person is an agent and has filed with the Commissioner, in a form satisfactory to the Commissioner, evidence that such person holds any license or authorization which may be required for the solicitation or sale of variable life insurance by any federal or state securities law.

(2) Any examination administered by the Department for the purpose of determining the eligibility of any person for licensing as an agent shall, after the effective date of this regulation, include such questions concerning the history, purpose, regulation, and sale of variable life insurance as the Commissioner deems appropriate.

(b) Reports of Disciplinary Actions. Any person qualified in this State under this Section to sell or offer to sell variable life insurance shall immediately report to the Commissioner:

(1) Any suspension or revocation of his agent's license in any other state or territory of the United States;

(2) The imposition of any disciplinary sanction, including suspension or expulsion from membership, suspension or revocation of or denial of registration, imposed upon him by any national securities exchange, or national securities association, or any federal, state, or territorial agency with jurisdiction over securities or variable life insurance, and

(3) Any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

(c) Refusal to Qualify Agent to Sell Variable Life Insurance. Suspension, Revocation, or Nonrenewal of Qualification. The Commissioner may reject any application or suspend or revoke or refuse to renew any agent's qualification under this Section to sell or offer to sell variable life insurance upon any ground that would bar such applicant or such agent from being licensed to sell other life insurance contracts in this State. The rules governing any proceeding relating to the suspension or revocation of an agent's license shall also govern any proceeding for suspension or revocation of an agent's qualification to sell or offer to sell variable life insurance.

§ 2534.10. Separability Provisions.

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Article 11.2. Separate Account or Accounts—Modified Guaranteed Annuities

§ 2534.20. Purpose.

The purpose of this article is to set forth rules and procedural requirements which are necessary to implement the provisions of California Insurance Code Section 10506 concerning the issuance and delivery of modified guaranteed annuity contracts in California, the payment of benefits thereunder, the manner in which the separate accounts required thereunder shall be established, maintained and administered and the administration of Article 16 (commencing with Section 1758.1), Chapter 5, Part 2, Division 1, of the Insurance Code relating to modified guaranteed annuity agents.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h), 10506.3(a) and 1758.1 Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).
2. Editorial correction adding inadvertently omitted Article heading (Register 95, No. 13).

§ 2534.21. Definitions.

As used in this article:

(a) "Modified guaranteed annuity" means a deferred annuity contract, individual or group, the underlying assets of which are held in a separate account, and the values of which are guaranteed if held for specified periods. The contract contains nonforfeiture values that are based upon a market–value adjustment formula if held for shorter periods. This formula may, or may not, reflect the value of assets held in the separate account. The assets underlying the contract must be in a separate account during the period, or periods, when the contract holder can surrender the contract;

(b) "Agent" means any person licensed as a life and disability or life only agent under the provisions of Chapter 5 (commencing with Section 1621), Part 2, Division 1, of the Insurance Code, more particularly defined in Section 1626 thereof;

(c) "Variable Contract Agent" means an agent licensed to transact, or required to be licensed to transact variable contracts by Article 16 (commencing with Section 1758.1), Chapter 5, Part 2, Division 1, of the Insurance Code;

(d) "Interest Credits" means all interest that is credited to the contract;

(e) "Separate Account" means a separate account established according to Section 10506, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer;

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h), 10506.3(a), 1621–1630, 1758.1–1758.5 and 10506, Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).

§ 2534.22. Obtaining Certification Permitting Transaction of Modified Guaranteed Annuity Business.

No insurer shall deliver or issue for delivery in this State any modified guaranteed annuity until it has received in writing from the Commissioner a certification that such insurer meets all the standards for transacting business required by California Insurance Code Section 10506. A certification may be obtained by filing an application (which includes the information specified in section 2534.23 or section 2534.24 of this article) with the Commissioner; payment of the minimum filing fee required by California Insurance Code Section 10506.1; and in the case of a domestic insurer, payment of an additional amount as may be assessed by the Commissioner pursuant to said California Insurance Code Section 10506.1. The application shall be verified by an executive officer of the insurer. The Commissioner shall advise applicants in writing within 90 days of receipt of the application whether the application is complete and accepted for filing; or, if the application is deficient the Commissioner shall advise the applicant what specific information is required. After a completed application is received, the Commissioner shall advise applicants, in writing, within one year whether certification is granted or denied.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h), 10506.3(a), 10506, 10506.1, Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).

§ 2534.23. Application of Domestic Insurers.

The application of a domestic insurer to write any modified guaranteed annuity shall include the following:

(a) A copy of the resolution of its board of directors, certified by the secretary or equivalent officer under corporate seal to be a full and true copy thereof, authorizing the establishing of one or more separate accounts for the purposes authorized by Section 10506;

(b) A copy of each written agreement specifying how each such separate account is to be established, maintained and administered, including for information purposes a copy of each modified guaranteed annuity proposed to be delivered or issued for delivery in California;

(c) A statement of the additional amount, if any, of the insurer's assets, other than those amounts received from modified guaranteed annuity holders for deposit in such a separate account, which have been allocated to a separate account pursuant to the authority of California Insurance Code Section 10506(b). No more than 1% of its admitted assets, or 5% of the excess of its admitted assets over its liabilities and required re-

serves, both as of the preceding December 31, whichever is the smaller, may be so allocated;

(d) A statement of the history, organization, ownership and control of the insurer. Any changes in organization, ownership or control which are contemplated shall also be set forth. Reference to past official examination reports, whether by California or other insurance regulatory authority, if appropriately brought up to date, is acceptable. Similarly, reference to other records bearing upon such matters, which have become part of the Commissioner's official files, are acceptable;

(e) A brief balance sheet statement of assets, liabilities, capital and surplus, as shown by its last filed Annual Statement. The Annual Statement filed will be relied upon for details;

(f) A complete statement of the plan and methods, including the marketing methods for the transaction of the modified guaranteed annuity and related business, which shall show:

(1) The status of the insurer of each of the separate accounts with the Federal Securities and Exchange Commission, including;

(A) Any exemption granted under Section 3(c)(11) of the Investment Company Act of 1940 and Section 3(a)(2) of the Securities Act of 1933;

(2) If any modified guaranteed annuity is to be issued without a prospectus, an explanation as to marketing methods, and upon request, for informational purposes, a copy of the advertising or solicitation material;

(3) The methods of control and management of each separate account, including the voting rights, if any, of participants, how they are exercised and their relation to the voting rights, if any, of members and shareholders of the insurer;

(g) If the insurer has not engaged actively in the insurance business for at least five years under substantially the same management and control, a biographical affidavit in a format prescribed by the Commissioner may, in the discretion of the Commissioner, be required for each of the executive officers, members of the board of directors and each natural person who owns 10% or more of the voting stock of the insurer;

(h) The identity, the experience and qualification of each of the persons charged with the investment management of each separate account, together with any other presentation which the insurer desires to make to establish the adequacy of the investment management which the insurer is providing. Such showing shall be such as to satisfy the Commissioner as to the experience and qualification of such management to effectively manage the investment program or programs envisaged by the agreement under which the separate account is established and maintained. A biographical affidavit in the format required by Paragraph (g) hereof may be required for each such manager;

(i) If the insurer is a subsidiary of an admitted insurer, or affiliated with such insurer by common control or management, it may be deemed by the Commissioner that the history, the reputation, the character, responsibility and general fitness of officers and directors, the adequacy of investment management as evidenced by past results, and the basic financial soundness of the parent insurer or the controlling affiliate satisfy these regulations;

Subsequent to qualification, any amendments to the above–mentioned resolution of the Board of Directors, agreement establishing a separate account, modified guaranteed annuity, registration statement or prospectus, and any substantial change in management shall promptly be filed with the Commissioner for review as to continuance of qualification standards required by law.

NOTE: Authority cited: Sections 10506.3(a) and 10506(h), Insurance Code. Reference: Sections 10506, 10506(b), 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).

§ 2534.24. Application of Foreign Insurer.

The application of a foreign insurer, including a Canadian insurer, shall include all of the matters required of a domestic insurer, except those specified in Paragraph (a) of Section 2534.23 hereof. The Commissioner shall give due regard to the regulatory activities of the applicant's domiciliary state in passing upon the qualifications of such foreign insurer to transact a modified guaranteed annuity business in California. If the Commissioner requires, a foreign insurer shall furnish a copy of the statutes and regulations of its domiciliary state under which it is authorized to transact a modified guaranteed annuity business and which regulate such transaction.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506, 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).

§ 2534.25. Certificate of Qualification Required.

If the Commissioner is satisfied after review of the application described in sections 2534.22, 2534.23, and 2534.24 of this article that the insurer meets the statutory requirements of California Insurance Code Section 10506 and that its proposed operations will not be hazardous to the public or its policyholders in this state, the Commissioner shall issue a certificate pursuant to Section 2634.22 of this article.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h), 10506.3(a), and 10506, Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).

§ 2534.26. Separate Account or Accounts.

A domestic insurer issuing modified guaranteed annuities shall establish one or more separate accounts pursuant to California Insurance Code Section 10506, subject to the following provisions:

(a) Separate account assets relating to modified guaranteed annuities will be subject to the investment laws of this state governing the investments of the insurer's general account assets. Separate account assets relating to modified guaranteed annuities shall be added to the insurer's general account assets in order to test conformity with investment laws governing general account assets.

(b) The same separate account may not be used for both variable annuities and variable life insurance, both variable annuities and modified guaranteed annuities or both variable life insurance and modified guaranteed annuities.

(c) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account.

(d) If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct.

(e) No sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such a transfer, whether into or from a separate account, is made either by a transfer of cash or by a transfer of securities having a valuation which could be readily determined in the marketplace, provided that such transfer of securities is approved by the Commissioner. The Commissioner may authorize other transfers among such accounts if, in the Commissioner's opinion, such transfers would not be inequitable.

(f) The provisions of California Insurance Code Sections 1101 through 1106 relating to conflicts of interest pertaining to officers and directors and other persons with authority in the management of the insurer's funds shall, in substance and insofar as they are reasonably applicable, apply to the investments of separate accounts and to members of any separate account committee, board or body who have any function in relation to the investment of the account assets. No officer or director of such insurer nor any member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 1101–1106, 10506, 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).

§ 2534.27. Filing and Approval of Policy Forms.

All modified guaranteed annuity policy forms (the term "policy forms" as used in this Section means any individual policy delivered or issued for delivery in this State and any document attached to and made a part of such policy, and any group policy delivered or issued for delivery in this state and any document attached to and made a part of such group policy and any group certificate delivered pursuant to the provisions of such group policy), including contracts providing fixed dollar benefits as may be included in the operation of any separate account shall be submitted to the Commissioner prior to delivery or issuance for delivery in this State, and no such form shall be delivered or issued for delivery in this State until the use of such form has been approved in writing by the Commissioner. Filings shall include a demonstration in a form satisfactory to the Commissioner that the nonforfeiture provisions of the contracts comply with Section 2534.28(b), as well as a certification by a member of the American Academy of Actuaries as to the compliance with Section 2534.28(b).

The Commissioner may disapprove any policy form which is unfair, unreasonable, or otherwise inconsistent with the provisions of the California Insurance Code. The fees for such approval shall be the fees set forth in California Code of Regulations, Title 10, Chapter 5, Subchapter 2, Section 2202(a)(10). The provisions of California Insurance Code Section 12957 shall be applicable to modified guaranteed annuity forms.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h), 10506.3(a) and 12957, Insurance Code.

HISTORY

1. New section filed 2–6–92; operative 3–9–92 (Register 92, No. 13).
2. Amendment of section and Note filed 11–9–2006; operative 11–9–2006 pursuant to Government Code section 11343.4 (Register 2006, No. 45).

§ 2534.28. Modified Guaranteed Annuity Contract Requirements.

(a) Mandatory Contract Benefit and Design Requirements.

(1) Any modified guaranteed annuity contract delivered or issued in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of nonforfeiture benefits.

(2) No modified guaranteed annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(A) A provision that there shall be a grace period of thirty (30) days or of one month during which the contract shall remain in force and, within which any payment due to the insurer other than the first may be made. The contract may include a statement of the basis for determining the date as of which any such payment received during the grace period shall be applied to produce the values under the contract;

(B) A provision that, at any time within one year from the date of default, the contract may be reinstated upon payment to the insurer of such overdue payments as required by contract, and of all indebtedness to the insurer on the contract, including interest. Reinstatement may not occur if the cash value has been paid. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract;

(C) A provision that, except and to the extent set out in contracts, the portion of the assets of any separate account which equal the reserves and other contract liabilities of the account shall not be chargeable with liabilities arising out of any other business of the company;

(3) The market–value adjustment formula, used in determining nonforfeiture benefits, must be stated in the contract and must be applicable for both upward and downward adjustments. When a contract is filed, it must be accompanied by an actuarial statement indicating the basis for the market–value adjustment formula and that the formula provides reasonable equity to both the contract holder and the insurance company.

(b) Nonforfeiture Benefits.

(1) This section shall not apply to any of the following:

(A) Reinsurance;

(B) Group annuity contracts purchased in connection with one or more retirement plans or deferred compensation plans established or maintained by or for one or more employers (including partnerships or sole proprietorships), employee organizations, or any combinations thereof, other than plans providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code;

(C) Premium deposit fund;

(D) Investment annuity;

(E) Immediate annuity;

(F) Deferred annuity contract after annuity payments have commenced;

(G) Reversionary annuity; or

(H) Any contract which is to be delivered outside this state by an agent or other representative of the company issuing the contract.

(2) No modified guaranteed annuity contract shall be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(A) When premium payments cease under a contract, the insurer will grant a paid–up annuity benefit on a plan described in the contract that complies with Paragraph (5) below. The provision will include a statement of the mortality table, if any, and guaranteed or assumed interest rates used in calculating annuity payments.

(B) If a contract provides for a lump sum settlement at maturity, or at any other time, upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay, in lieu of any paid–up annuity benefit, a cash surrender benefit as described in the contract that complies with Paragraph (8) below. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand thereof with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral.

(3) The minimum values, as specified in this section, of any paid–up annuity, cash surrender or death benefits available under a modified guaranteed annuity contract shall be based upon nonforfeiture amounts meeting the requirements of this paragraph. In addition, pursuant to Insurance Code section 10506.3(a), the provisions of Insurance Code Article 3B (commencing with section 10168) of Chapter 1 of Part 2 of Division 2 with regard to nonforfeiture values shall apply to the Unadjusted Minimum Nonforfeiture Amount, as an absolute minimum. The Unadjusted Minimum Nonforfeiture Amount on any date prior to the annuity commencement date shall be an amount equal to the net considerations (as specified in Paragraph (6) below) increased by the interest credits as defined in Section 2534.21 of these regulations allocated to the net considerations, which amount shall be reduced to reflect the effect of Subparagraphs (A), (B), (C), and (D) below:

(A) Any prior withdrawals from or partial surrenders of the contract increased by the interest credits defined in Section 2534.21;

(B) An annual contract charge of $50, increased by the interest credits defined in Section 2534.21;

(C) Any premium tax paid by the company for the contract, increased by the interest credits defined in Section 2534.21. The premium tax credit is only permitted if the tax is actually paid by the company. If the tax is paid and subsequently credited back to the company, such as upon early termination of the contract, the tax credit may not be taken; and

(D) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(4) Guaranteed interest credits in each year for any period of time for which interest credits are guaranteed shall be reasonably related to the average guaranteed interest credits over that period of time.

(5) The Minimum Nonforfeiture Amount shall be the Unadjusted Minimum Nonforfeiture Amount adjusted by the market-value adjustment formula contained in the contract.

(6) The net considerations for a given contract year used to define the minimum nonforfeiture amount in subsection 2534.28(b)(3) shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

(7) Any paid-up annuity benefit available under a modified guaranteed annuity contract shall be such that its present value on the annuity commencement date is at least equal to the Minimum Nonforfeiture Amount on that date. Such present value shall be computed using the mortality table, if any, and the guaranteed or assumed interest rates used in calculating the annuity payments.

(8) For modified guaranteed annuity contracts which provide cash surrender benefits, the cash surrender benefit at any time prior to the annuity commencement date shall not be less than the Minimum Nonforfeiture Amount next computed after the request for surrender is received by the insurer. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(9) Any modified guaranteed annuity contract which does not provide cash surrender benefits, or does not provide death benefits at least equal to the Minimum Nonforfeiture Amount, prior to the annuity commencement date shall include a statement in a prominent place in the contract that such benefits are not provided.

(10) Notwithstanding the requirements of this section, a modified guaranteed annuity contract may provide under the situations specified in Subparagraphs (A) or (B) below that the insurer, at its option, may cancel the annuity and pay the contract holder the larger of the Unadjusted Minimum Nonforfeiture Amount and the Minimum Nonforfeiture Amount, and by such payment be released of any further obligation under the contract:

(A) If, at the time the annuity becomes payable, the larger of the Unadjusted Minimum Nonforfeiture Amount and the Minimum Nonforfeiture Amount is less than $2,000, or would provide an income the initial amount of which is less than $20 per month; or

(B) If, prior to the time the annuity becomes payable under a periodic payment contract no considerations have been received under the contract for a period of two (2) full years and both:

(i) The total considerations paid prior to such period, reduced to reflect any partial withdrawals from or partial surrenders of the contract, and

(ii) The larger of the Unadjusted Minimum Nonforfeiture Amount and the Minimum Nonforfeiture Amount is less than $2,000.

(11) For any modified guaranteed annuity contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Subparagraph 2534.28(b) additional benefits are payable under the following conditions:

(A) In the event of total and permanent disability,

(B) As reversionary annuity or deferred reversionary annuity benefits, or

(C) As other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require Minimum Nonforfeiture Amounts, paid-up annuity, cash surrender and death benefits.

(c) The Application. The application for a modified guaranteed annuity shall prominently set forth language substantially stating that amounts payable under the contract are subject to a market-value adjustment prior to a date or dates specified in the contract. The statement shall be placed immediately above the signature line.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2-6-92; operative 3-9-92 (Register 92, No. 13).
2. Amendment of section and Note filed 11-9-2006; operative 11-9-2006 pursuant to Government Code section 11343.4 (Register 2006, No. 45).

§ 2534.29. Reserve Liabilities.

The reserve liabilities for modified guaranteed annuities shall be established in accordance with actuarial procedures that recognize:

(a) That assets of the separate account are based on market values;

(b) The variable nature of benefits provided; and

(c) Any mortality guarantees.

As a minimum, the separate account liability will equal the surrender value based upon the market-value adjustment formula contained in the contract. If that liability is greater than the market value of the assets, a transfer of assets will be made into the separate account so that the market value of the assets at least equals that of the liabilities. Also, any additional reserve that is needed to cover future guaranteed benefits will also be set up by the valuation actuary.

The market-value adjustment formula, the interest guarantees, and the degree to which projected cash flow of assets and liabilities are matched must also be considered. Each year, the valuation actuary must provide an opinion on whether the assets in the separate account are adequate to provide all future benefits that are guaranteed.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2-6-92; operative 3-9-92 (Register 92, No. 13).

§ 2534.30. Required Reports.

Any insurer issuing individual modified guaranteed annuities shall mail to the contractholder at least once in each contract year at his or her last known address, a report showing both the account value and the cash surrender value. The insurer shall not be required to mail such a report during the first contract year. The report shall clearly indicate the account value prior to the application of any surrender charges or market value adjustment formula. It shall also specify the surrender charge and market value adjustment used to determine the cash surrender value.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2-6-92; operative 3-9-92 (Register 92, No. 13).

§ 2534.31. Foreign Insurers.

If the law or regulation in the place of domicile of a foreign insurer or the state of entry of a Canadian insurer provides a degree of protection to the policyholders and the public which is substantially equal to that provided by this article, the Commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with this article.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h) and 10506.3(a), Insurance Code.

HISTORY

1. New section filed 2-6-92; operative 3-9-92 (Register 92, No. 13).

§ 2534.32. Authorization of Agents.

No person may act as an agent for a life insurer in the transaction of modified guaranteed annuities unless and until he has received from the Commissioner a license as a variable contract agent pursuant to Article 16 (commending with Section 1758.1), Chapter 5, Part 2, Division 1, of the Insurance Code.

NOTE: Authority cited: Sections 10506(h) and 10506.3(a), Insurance Code. Reference: Sections 10506(h), 10506.3(a) and 1758.1 through 1758.5, Insurance Code.

HISTORY

1. New section filed 2-6-92; operative 3-9-92 (Register 92, No. 13).

Article 11.3. Mutual Fund Investments in Variable Products

§ 2534.40. Purpose.

The purpose of this article is to implement the provisions of Insurance Code Section 10506, subdivision (h) as amended by Assembly Bill 2778 (Calderon) (Statutes of 2002, Chapter 347). Pursuant to the statute, these regulations supersede Insurance Department Bulletin 97–2.

NOTE: Authority cited: Section 10506(h), Insurance Code. Reference: Section 10506(h), Insurance Code.

HISTORY

1. New article 11.3 (sections 2534.40–2534.46) and section filed 12–13–2006; operative 1–12–2007 (Register 2006, No. 50).

§ 2534.41. Definitions.

(a) For purposes of this article, "Mutual Fund Investments" include but are not limited to, investments that are registered with the Securities and Exchange Commission pursuant to the Investment Company Act of 1940 (15 U.S.C. 80a–1). Private placement investments involving non–mutual fund investments are specifically excluded from this definition.

(b) Filings with the Commissioner, pursuant to Section 2534.46 of this article, are deemed to be notifications as delineated in Insurance Code Section 10506, subdivision (h).

(c) For purposes of this article, the terms "subaccounts" and "portfolios" are interchangeable.

(d) For purposes of this article, the term "variable product" is defined as any group or individual variable life insurance policy or variable annuity contract as described in Insurance Code Section 10506.

(e) For purposes of this article, the term "hazardous operation" is defined as the issuance of any contract that may pose a hazard to California policyholders or the public, that fails to adequately disclose any material risk, or contains any of the factors delineated in Section 2534.44 of this article.

NOTE: Authority cited: Section 10506(h), Insurance Code. Reference: Section 10506(h), Insurance Code.

HISTORY

1. New section filed 12–13–2006; operative 1–12–2007 (Register 2006, No. 50).

§ 2534.42. Notifications and Procedures Concerning Hazardous Operations.

(a) Variable products may be reviewed to determine if the investments involve hazardous operations.

(b) Hazardous operations shall not exist if the variable product issued, or issued for delivery, in this state:

(1) has underlying investment portfolio(s) that are registered under the Investment Company Act of 1940, regardless of whether such underlying portfolio(s) meet the criteria set forth in Section 2534.45 of these regulations;

(2) is issued in connection with a plan that is subject to the fiduciary standards of the Employee Retirement Income Security Act of 1974 (ERISA) or is issued in connection with a welfare benefit, deferred compensation, pension, profit sharing, or retirement plan established or maintained by or for a plan sponsor;

(3) is a variable life insurance contract issued under California Insurance Code Section 10506.3;

(4) is issued under California Insurance Code Section 10541 to entities such as a trust or foundation;

(5) or is issued only to "accredited investors" as that term is defined in Section 501(a) of Regulation D, promulgated under the Securities Act of 1933, (17 CFR Section 230.501(a)) or to "qualified purchasers" as that term is defined in Section 2(a)(51)(A) of the Investment Company Act of 1940, (15 USC §80a–2(a)(51)(A)).

(c) Notwithstanding the above, the Commissioner reserves the right to review any variable product falling into any of the above categories for possible hazardous operations where he deems there is good cause to believe that the issuance of such a product may pose a hazard to California policyholders or the public, or where he finds that any material risk is not adequately disclosed.

(d) If the Commissioner determines that hazardous operations are involved, the following procedure will be utilized:

(1) The insurer will be notified of the Commissioner's initial finding regarding hazardous operations. At that time, the insurer will be given a reasonable opportunity to present a response consisting of evidence to refute the Commissioner's initial findings. Such response shall be given within 30 days of the service of the Commissioner's initial findings.

(2) If the insurer fails to provide satisfactory evidence that hazardous operations are not involved in the variable product, pursuant to the authority of Article 14.5., Chapter 1., Part 2., Division 1. of the Insurance Code, commencing with section 1065.1, the Commissioner shall issue such order or orders as are necessary to support his or her findings regarding hazardous operations. Such orders shall include, but not be limited to, the prohibition of the sale, issuance and delivery of an insurance policy or contract. The Commissioner may exercise all other powers provided in Article 14.5. Any hearing held pursuant to this article shall be before an administrative law judge of the Administrative Hearing Bureau of the Department of Insurance.

NOTE: Authority cited: Sections 1065.1 and Section 10506(h), Insurance Code. Reference: Sections 1065.1 and Section 10506(h), Insurance Code.

HISTORY

1. New section filed 12–13–2006; operative 1–12–2007 (Register 2006, No. 50).

§ 2534.43. [Reserved.]

§ 2534.44. Factors Determining the Existence of Hazardous Operations.

(a) When a variable annuity is utilized for retirement purposes, it shall be deemed that the prospective purchaser or contract holder holds the viewpoints and expectations of a reasonably prudent investor. The reasonably prudent investor generally does not participate in highly speculative investments, but does have expectations of a reasonable rate of return on his or her investment. Over the long term, such an investor expects to see moderate growth in his or her investment, over a time frame consistent with his or her retirement plans and taking into account his or her ability to make appropriate investment strategy changes as conditions and expectations change over time.

(b) However, the types of investments and degrees of investment risks appropriate for a reasonably prudent investor should be determined in light of the specific situation and characteristics of a given individual. Factors to be considered include the individual's age, wealth, other investments, dependents and financial obligations, long term financial prospects, lifestyle preferences, and tolerance of risk.

(c) In addition, brokers and agents selling variable products must comply with suitability standards. Such standards obligate the broker or agent to make certain that there are reasonable grounds for believing that a variable contract recommended to a customer is suitable for that customer. It is expected that due diligence will be given to the consideration of suitability by brokers and agents licensed to sell variable contracts in California.

(d) A variable annuity shall be considered to have hazardous operations when the variable annuity contract, viewed as a whole, and from the viewpoint of a reasonably prudent investor, is so risky an investment that it seriously jeopardizes the retirement expectations of the investor. If the investor's reasonable retirement expectations are in jeopardy of remaining substantially unfulfilled, the presumption could arise that the contact is hazardous.

(e) A variable life insurance contract shall be considered to have hazardous operations when the variable life insurance contract, viewed as a whole, and from the viewpoint of a reasonably prudent investor, contains risky investment options which the Commissioner deems excessive. In addition, such options jeopardize the realization of a fair, investment return, over a long period of time. Where the insurer informs the investor of a significant number of risks and uses an unusually large number of caveats in its explanation of the policy and its investment options, a presumption shall arise that the policy is hazardous.

(f) To the extent that an insurer's financial condition, or methods of operation, places the reasonable prudent investor in jeopardy of having his or her investment expectations substantially unfulfilled, that financial condition or business operation shall be presumed to involve hazardous operations.

(g) The presence of the following factors may raise a presumption that hazardous operations are involved in a variable product, fund or subaccount.

(1) Operations are delegated to a third party that is not a lawfully licensed agent of the company.

(2) The name of the subaccount is deceptive.

(3) The investment restrictions of the subaccount permit it to invest more than 20% of its assets in bonds rated less than investment grade, by a bond–rating agency such as Moody's or Standard and Poors. Such an investment will not be permitted unless the subaccount specifically identifies and discloses the nature of the investment and the attendant risks associated with it.

(4) The investment restrictions of the subaccount permit borrowings to reach a level greater than 33 1/3% of its total assets.

(5) The investment restrictions of the subaccount permit it to hedge by purchasing put and call options, futures contracts, or derivative instruments on securities in an aggregate amount equivalent to more than 10% of its total assets.

(6) The investment adviser or subadviser does not possess sufficient investment experience in order to render reliable investment advice. Advisers must be of good professional character and in good standing with the securities licensing authorities having jurisdiction over them.

(7) The portfolio turnover rate is excessive in relation to the investment goals of the subaccount. A high portfolio turnover rate shall not be considered excessive if it is consistent with the investment objectives of the portfolio or subaccount.

(8) An index subaccount must substantially mirror the stock index upon which it is based.

(9) References to rating services, such as A.M. Best, in advertising must explain the nature and purpose of the rating. The reference must clearly indicate that the rating does not apply to the insurer's Separate Account(s).

(10) Hazardous operations may exist if the entire assets of the Separate Account are composed wholly, or in very large part, of investments in other Separate Accounts, not under the direct control of the insurer. In such situations, hazard will exist if the liquidity of the Separate Account is impaired.

(11) Hazardous operations may exist if investments are made directly in gold and/or silver bullion which, when combined, exceed 10% of the assets of the underlying subaccount.

(12) Hazardous operations may exist in non–income producing real estate. Such investments will be presumed speculative.

Concerning International and Global Portfolios or Subaccounts:

(13) Such subaccounts must be sufficiently diversified. Diversification requires that investments must be made in a minimum of three different countries at all times. The subaccount must not invest more than 50% of its assets in any second tier country or more than 25% of its assets in any third tier country. First tier countries are defined as Germany, the United Kingdom, Japan, the United States, France, Canada, and Australia. Second tier countries are all countries not in the first or third tier. Third tier countries are defined as countries identified as "emerging" or "developing" by the International Bank for Reconstruction and Development (also known as the "World Bank") or the International Finance Corporation.

(14) Regional subaccounts must be invested in a minimum of three countries and the name of the subaccount must accurately describe the subaccount. Similarly, a subaccount that uses the name of a single country to describe it must make substantial investments in that country and the name of the subaccount must accurately describe the nature of the subaccount.

(h) Notwithstanding the above presumptive factors, the Commissioner reserves the right to review for possible hazardous conditions any variable contract if there is good cause to believe that the issuance of such contract may pose a hazard to California policyholders or the public. The Commissioner may also review any variable contract if there is good cause to find that any material risk is not being adequately disclosed.

NOTE: Authority cited: Section 10506(h), Insurance Code. Reference: Section 10506(h), Insurance Code.

HISTORY

1. New section filed 12–13–2006; operative 1–12–2007 (Register 2006, No. 50).

§ 2534.45. Completeness Review of Variable Product Filings.

(a) The following documents, fully and accurately completed, must be included in a submission of an amended variable annuity or amended variable life application. All documents in a submission must be presented in the same order as indicated below. Any submission not in compliance with the following requirements or presented in the following order will be returned to the filer.

(1) Filings must contain a cover letter explaining the nature of the filing. The letter should explicitly indicate the names of each Mutual Fund being used as an underlying investment for the variable product. The letter must explain if the subject of the filing is a new product, fund and/or subaccount. The letter must clearly indicate the nature of the proposed changes to the company's variable authority, and identify the category in 10 CCR 2534.42(b) which applies to the investments. For example, if the filer is using the Other Material Changes form, the nature of the changes to the insurer's variable authority must be clearly described in the cover letter. The letter shall name the person responsible for the filing and provide contact information for the responsible person. Such contact information shall contain an electronic mail address, if available.

(2) Filings must include a Certificate of Compliance as set forth in section 2534.46(a)(1) of this article. The Certificate must be notarized, dated and executed over the corporate seal. The Certificate must be executed by an executive officer of the insurer, who has responsibility for the insurer's variable contract operations. By executing the Certificate, the officer is attesting that he or she has read Title 10 Code of California Regulations sections 2534.40–2534.46. A New Matters Form, as set forth in section 2534.46(a)(2) of this article, must be completed setting out the changes being made in the variable product.

(3) If a new product is being introduced, a New Product Form, as set forth in section 2534.46(a)(3) of this article, must be completed. In addition, a currently effective product prospectus and Statement of Additional Information, as filed with the Securities and Exchange Commission, for the new product must be filed. The prospectus and Statement of Additional Information may be provided in CD–ROM form.

(4) If a new fund is being added, a New Fund Form, as set forth in section 2534.46(a)(4) of this article, must be completed. A currently effective Fund Prospectus and Statement of Additional Information must be included. If there have been any supplements to the prospectus or Statement of Additional Information, they must also be included. Such documents may be provided in CD–ROM form.

(5) If a new subaccount or portfolio is being added, a New Subaccount Form, as set forth in section 2534.46(a)(5) of this article, must be completed.

(6) For all other material changes, an Other Material Changes form, as set forth in section 2534.46(a)(6) of this article, must be completed.

(7) Filings concerning new subaccounts may not contain more than 25 new subaccounts per product and a New Subaccount Form should be completed for each new subaccount. If an insurer is adding more than 25 new subaccounts, the filing must be divided into two or more separate filings. For example, a filing adding 30 new subaccounts must be divided into one filing with 25 new subaccounts and another filing with five new subaccounts.

(8) Copies of any previous acknowledgment letters for the new fund(s) and/or subaccount(s) that were issued pursuant to Insurance Department Bulletin 97–2.

(9) If there are investment guidelines or restrictions that are not contained in the currently effective Fund Prospectus and Statement of Additional Information, they must be filed at the time of the application.

(10) The applicable fees pursuant to Insurance Code sections 10506.2 and 12978.

(11) The Commissioner shall determine whether a filing for a material change is complete and complies with filing requirements. If the filing for a material change includes the forms listed in sections 2534.46 and 2534.47 of this article and the data required therein, the filing is complete.

(b) Filings shall be addressed to California Department of Insurance, Policy Approval Bureau, 45 Fremont Street, 24th Floor, San Francisco, California 94105.

(c) If the Commissioner determines that a filing for a material change fails to comply with filing requirements or is incomplete, the Commissioner shall issue a letter rejecting the filing for a material change.

NOTE: Authority cited: Section 10506(h), Insurance Code. Reference: Section 10506(h), Insurance Code.

HISTORY

1. New section filed 12–13–2006; operative 1–12–2007 (Register 2006, No. 50).

§ 2534.46. Forms.

(a) The following forms shall be used pursuant to this article:

(1) Certificate of Compliance:

VARIABLE CONTRACT CERTIFICATE OF COMPLIANCE

Name of Applicant Company:

Address:

Date:

Person to Whom Correspondence Should Be Addressed:

(Directions: This Certificate may be utilized in lieu of applicant seeking a prior approval of its changes in its variable contract operation; such an approval being based upon a full review by the Department. This Certificate must be executed by an executive officer of the applicant, who has responsibility for applicant's variable contract operation. Please answer each question in the accompanying Forms completely. If more room is needed, attach a sheet of paper indicating the question being responded to.)

TO THE INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA

I, [_____], a duly appointed executive officer of the Applicant Company, having responsibility for its variable contract operation, do state, under oath, that I have carefully read this Certification and the attached Forms, and that the information and answers to questions herein is true to the best of my own knowledge, except as to those specifically stated to be upon information and belief, and as to those I believe the answers to be true.

Further I state that the variable contract changes described herein comply with pertinent statutes, regulations, and bulletins, and have been reviewed by me, or that I have been advised by competent legal counsel, representing the company, that the changes are in full compliance with the California Insurance Code, Regulations, Bulletins, and underlying guidelines. In particular, I state that this filing complies with Title 10 California Code of Regulations sections 2534.40–2534.46.

All material changes occurring since my company's most recent amendment of its variable contract qualification, (and the approval or acknowledgment by the Department of that amendment), are explained and described herein, or in accompanying materials and documentation. The information given here does not relate to any changes previously submitted to the Department and disapproved by the Department, unless corrective action has been taken by my company to meet the objections previously stated by the Department to those changes.

I understand and acknowledge that false statements which are intended to mislead or deceive the Commissioner, or the willful omission of any material fact with the same intent, may be punishable under such sections of the Insurance Code as may be applicable.

WITNESS MY SIGNATURE this [_____] day of [_____], [___], at [_____].

Signature [_____]
(Affiant)

[_____]
(Printed or typed name and title)

SUBSCRIBED AND SWORN TO before me on the date and year above written.

[_____]
(Notary Public in and for said County and State)

My commission expires [_____]

(2) New Matters Form:

DESCRIPTION OF NEW MATTERS FORM

1. **Background Information:**
   a. Applicant's name:
   b. Applicant's state of domicile:
   c. Date of applicant's California Certificate of Authority:
   d. Date of applicant's original qualification for California Variable Authority:
   e. Date and type of applicant's last amendment to its California Variable Authority:
   f. What variable products is the applicant currently offering in California?
   g. Has the applicant ever been subject to a regulatory disciplinary action, at either a state or federal level, for actions arising out of its variable annuity or variable life business? If yes, identify each action:
2. What amendments to the applicant's current variable qualification are being requested in this application? (Be sure to include a new product form, new fund form, new subaccount/portfolio form and/or other material changes form for each applicable amendment).
   a. New Product:
   b. New Fund:
   c. New Subaccount/Portfolio:
   d. Other Material Changes:
3. Has the applicant included an original certificate of compliance?
4. Please identify the type(s) of investments presented in this application (for example):
   a. Mutual Fund (2534.42 (b)(1))
   b. ERISA or Other Plan (2534.42.(b)(2))
   c. California Insurance Code Section 10506.3 Product (2534.42(b)(3))

d. Issued to a trust under California Insurance Code Section 10541 (2534.42(b)(4)

e. Private Placement (2534.42(b)(5))?

5. If the amendments set forth in the application require a filing with the Securities and Exchange Commission, the application must include an effective prospectus and statement of additional information. **Applications for amended variable qualification will not be accepted for filing until an effective prospectus has been submitted.**

6. If the amendments set forth in the application do not require a filing with the Securities and Exchange Commission, the application must include a private placement memorandum or comparable disclosure documentation available to purchasers of the product(s). **Applications for amended variable qualification will not be accepted for filing until disclosure documents have been submitted**

(3) New Product Form

NEW PRODUCT FORM

1. **PRODUCT NAME:** What is the name of the New Product?

2. **PRODUCT DESCRIPTION:** Provide a brief description of the New Product.

3. **POLICY FORM:** Attach a specimen copy of the New Product policy form.

4. **MARKETING:** How will this new product be marketed? Who will be the target market for this new product? Attach copies of any advertising or marketing information that will be distributed to the applicant's marketing agents and/or sales force.

5. **DISTRIBUTION:** How will the New Product be distributed? Will a third party handle distribution? If yes, attach a copy of the distribution agreement.

6. **ADMINISTRATION:** Will the administration of this New Product be delegated to a third party? If yes, attach a copy of the administration agreement. Administration of a life or annuity product by a third party will require a third party administrator's license (California Insurance Code Section 1759).

7. **SALES COMMISSION:** What is the sales commission on this New Product?

8. **SURRENDER CHARGE:** What is the surrender charge on the New Product?

9. **CONTRACT FEE:** What is the annual contract fee on this New Product?

10. **MORTALITY AND EXPENSE RISK CHARGES:** What are the mortality and expense risk charges on this New Product?

11. **PRODUCT PROSPECTUS AND STATEMENT OF ADDITIONAL INFORMATION:** Does this new product require the filing of a prospectus with the Securities and Exchange Commission? If yes, attach a copy of the product prospectus and statement of additional information. (All insurers must provide an effective product prospectus and statement of additional information before an application to amend their variable qualification will be accepted for filing).

12. **PLAN DOCUMENTS:** If this New Product is not subject to filing with the Securities and Exchange Commission, attach a copy of the Plan Documents or other documentation which provides information about the new product.

(4) New Fund Form:

NEW FUND FORM

1. **FUND NAME:** What is the name of the New Fund?

2. **INVESTMENT ADVISOR:** Who is the investment advisor for the new fund? Attach a copy of the investment advisory agreement.

3. **DISTRIBUTOR:** Who is the distributor (broker/dealer) for the New Fund?

4. **USE OF FUND(S) BY OTHER INSURANCE COMPANIES:** Has this New Fund ever been qualified for use in California as an investment for variable products? If yes, please provide the names of the insurance companies you know are qualified to offer this fund.

5. **DISCIPLINARY ACTIONS:** Has this New Fund, its investment advisor or its broker–dealer been subject to any disciplinary action by the Securities and Exchange Commission, the California Department of Corporations or any other State securities regulator, the National Association of Securities Dealers or any other self–regulatory organizations, or the Commodities Futures Trading Commission within the past ten years? If yes, attach a copy of each action.

6. **FUND PROSPECTUS AND STATEMENT OF ADDITIONAL INFORMATION:** Does this New Fund require a filing with the Securities and Exchange Commission? If yes, attach a copy of the effective fund prospectus and statement of additional information. The fund prospectus and statement of additional information must be effective before the application for amended variable qualification will be accepted for filing.

7. **PLAN DOCUMENTS:** If the New Fund is not subject to filing with the Securities and Exchange Commission, attach a copy of the Plan Documents or other documentation which provides information about the New Fund.

(5) New Subaccount Form:

NEW SUBACCOUNT FORM

1. **SUBACCOUNT NAME:** What is the name of the New Subaccount?

2. **INVESTMENT OBJECTIVE:** What is the principal investment objective of the New Subaccount?

3. **SUBACCOUNT MANAGER:** Who is the Subaccount manager for the New Subaccount?

4. **FEES:** Are any fees charged by the New Subaccount? If yes, identify each charge.

5. **DISCIPLINARY ACTIONS:** Has the New Subaccount or its portfolio manager been subject to any disciplinary action by the Securities and Exchange Commission, the California Department of Corporations or any other State securities regulator, the National Association of Securities Dealers or any other self–regulatory organizations, or the Commodities Futures Trading Commission within the past ten years? If yes, attach a copy of the action.

6. **PROSPECTUS AND STATEMENT OF ADDITIONAL INFORMATION:** Does the New Subaccount require a filing with the Securities and Exchange Commission? If yes, attach a copy of the effective product and/or fund prospectus and statement of additional information relating to the addition of this New Subaccount. The product and/or fund prospectus must be effective before the application for amended variable qualification will be accepted for filing.

7. **PLAN DOCUMENTS OR OTHER INFORMATIONAL MATERIAL:** If the New Subaccount is not subject to Securities and Exchange Commission filing, attach a copy of the Plan Documents or

other informational material which provides information about the subaccount/portfolio.

(6) Other Material Changes Form:

OTHER MATERIAL CHANGES

1. **OTHER MATERIAL CHANGES:** Identify any material changes to the applicant's current variable qualification.

(Examples of material changes are as follows: 1) change of custodian; 2) change of administrator; 3) change of broker/dealer; 4) change of investment advisor; 5) change of portfolio manager; 6) change in fund or portfolio name; 7) change in fund or portfolio investment objective; 8) disciplinary action taken by the Securities and Exchange Commission, the California Department of Corporations or any other State securities regulator, the National Association of Securities Dealers or any other self–regulatory organizations, or the Commodities Futures Trading Commission against fund, investment advisor, portfolio manager or broker/dealer; 9) regulatory action against the insurer arising out of its variable annuity or variable life business; 10) amendments to: a) the Board of Directors resolutions, b) the agreement establishing the separate account, c) the variable contract, or d) registration statement or prospectus; and 11) any substantial change in management of the Separate Account).

2. **PROSPECTUS AND STATEMENT OF ADDITIONAL INFORMATION:** If filing with the Securities and Exchange Commission is required for any of the changes listed above, attach a copy of the effective prospectus and statement of additional information which reflects these changes.

3. **PLAN DOCUMENTS:** If filing with the Securities and Exchange Commission for any of the changes identified above is not required, attach a copy of the Plan Documents or other documentation which provides information about these changes.

NOTE: Authority cited: Section 10506(h), Insurance Code. Reference: Section 10506(h), Insurance Code.

HISTORY

1. New section filed 12–13–2006; operative 1–12–2007 (Register 2006, No. 50).

Article 12. Disability Insurance Advertisements

§ 2535. Authority.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Section 790.10 of the Insurance Code.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Section 790.03, Insurance Code.

HISTORY

1. New Article 12 (Sections 2535, 2535.1, 2535.2, 2536, 2536.1–2536.15, 2537, 2537.1) filed 5–12–72; effective thirtieth day thereafter (Register 72, No. 20).
2. Repealer of Article 12 and new Article 12 (Sections 2535, 2535.1–2535.3, 2536, 2536.1–2536.12, 2537.1, 2537.2) filed 4–2–73; effective thirtieth day thereafter (Register 73, No. 14).

§ 2535.1. Purpose.

The purpose of these regulations is to assure truthful and adequate disclosure of all material and relevant information in the advertising of disability insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of disability insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media. Subdivisions (a), (b) and (c) of Insurance Code Section 790.03 prohibit the transmitting or use of information in the form of advertisements or otherwise in this State in such a manner or of such substance that the insurance buying public may be deceived or misled. Since such sections of the Insurance Code establish only general standards, these regulations establish specific standards for advertisements relating to individual, group, blanket and selected group (franchise) disability insurance. These regulations are applicable to all persons and entities specified in Insurance Code Section 790.01 authorized to transact disability insurance in this State. The following specific standards for advertisements of disability insurance are hereby adopted.

GUIDELINE 2535.1

Disclosure is one of the principal objectives of these regulations and this Section states specifically that the rules shall assure "truthful and adequate disclosure of all material and relevant information." These rules specifically prohibit some previous advertising techniques.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2535.2. Applicability.

(a) These regulations shall apply to any disability insurance "advertisement," as that term is hereinafter defined in Sections 2535.3(a), (g), (h) and (i), unless otherwise specified in these regulations, intended for presentation, distribution or dissemination in this State when such presentation distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker or solicitor as those terms are defined in the Insurance Code of this State and these regulations.

GUIDELINE 2635.2(a)

These regulations apply to any "advertisement" as that term is defined in Sections 2535.3(a), (g), (h) and (i), unless otherwise specified in these regulations. These regulations apply to group and blanket as well as individual accident and sickness insurance. Certain distinctions, however, are applicable to these categories. Among them is the level of conversance with insurance, a factor which is covered by Section 2536.1 of these regulations.

(b) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised.

GUIDELINE 2535.2(b)

Advertising materials which are reproduced in quantity shall be identified by form numbers or other identifying means in the case of advertisements not subject to the requirements of Section 2536.9. Such identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2535.3. Definitions.

(a) An advertisement for the purpose of these regulations shall include:

(1) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays; and

(2) Descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(3) Prepared sales talks, presentations and material for use by agents, brokers and solicitors.

GUIDELINE 2535.3(a)

The scope of the term "advertisement" extends to the use of all media for communication to the general public (Section 2535.3(a)(1), to the use of all media for

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communication to specific members of the general public (Section 2535.3(a)(2) and to the use of all media for communication by agents, brokers and solicitors.

The definition of "advertisement" includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

The definition of "advertisement" does not include: (1) material to be used solely for the training and education of an insurer's employees, agents or brokers; (2) material in house organs of insurers; (3) communications within an insurer's own organization not intended for dissemination to the public; (4) individual communications of a personal nature with current policyholders other than material urging such policyholders to increase or expand coverages; (5) correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract; (6) court approved material ordered by a court to be disseminated to policyholders; or (7) a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged; provided, the announcement clearly indicates that it is preliminary to the issuance of a booklet.

(b) "Policy" for the purpose of these regulations shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides disability benefits, or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life, and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.

GUIDELINE 2535.3(b)

In Section 2535.3(b), the language "except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts" means except disability, waiver of premium and double indemnity benefits included in life insurance, endowment or annuity contracts or contracts supplemental thereto which contain only such provisions which: (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or as (b) operate to safeguard such contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled as defined by the contract or supplemental contract.

The term "disability benefits" includes benefits for death or dismemberment or loss of sight by accident.

(c) "Insurer" for the purpose of these regulations shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity which is defined as an "insurer" in the Insurance Code of this State and is engaged in the advertisement of a policy as "policy" is defined in these regulations.

(d) "Exception" for the purpose of these regulations shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

(e) "Reduction" for the purpose of these regulations shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

(f) "Limitation" for the purpose of these regulations shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(g) "Institutional Advertisement" for the purpose of these regulations shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.

(h) "Invitation to Inquire" for the purpose of these regulations shall mean an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable, and which may contain:

(1) The dollar amount of benefit payable, and/or

(2) The period of time during which the benefit is payable; provided the advertisement does not refer to cost.

An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."

(i) "Invitation to Contract" for the purpose of these regulations shall mean an advertisement which is neither an invitation to inquire nor an institutional advertisement.

GUIDELINES 2535.3(c) THROUGH 2535.3(i)

These subsections are self-explanatory.

HISTORY

1. Amendment and new subsections (g), (h), and (i) filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536. Method of Disclosure of Required Information.

All information required to be disclosed by these regulations shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

GUIDELINE 2536

This Section permits the use of either of the following alternative methods of disclosure:

(1) The first alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions conspicuously and in close conjunction with the statements to which such information relates. This may be accomplished by disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits.

(2) The second alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Exclusions," "Conditions Not Covered" and "Exceptions and Reductions." The use of captions such as, or similar to, the following are not acceptable because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only these Exclusions" or "Minimum Limitations."

In considering whether an advertisement complies with the disclosure requirements of this Section, the Section must be applied in conjunction with the form and content standards contained in Section 2536.1.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.1. Form and Content of Advertisements.

(a) The format and content of an advertisement of a disability insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

GUIDELINE 2536.1(a)

This Section must be applied in conjunction with Sections 2535.1 and 2536 of the regulations. This Section refers specifically to "format and content" of the advertisement and the "overall" impression created by the advertisement. This involves factors such as, but not limited to, the size, color and prominence of type used to describe benefits. The word "format" means the arrangement of the text and the captions.

This rule requires distinctly different advertisements for publication in newspapers or magazines of general circulation as compared to scholarly, technical or business journals or newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independently of all other pieces of material, conform to the disclosure requirements applicable to the appropriate form of advertisement as defined in Section 2536.3(g) through (i) of these regulations.

(b) Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

GUIDELINE 2536.1(b)

The Section prohibits the use of incomplete statements and words or phrases which have the tendency or capacity to mislead or deceive because of the reader's unfamiliarity with insurance terminology. Therefore, words, phrases and illustrations used in an advertisement must be clear and unambiguous and, if the advertisement uses insurance terminology, sufficient description of a word, phrase or illustration shall be provided by definition or description in the context of the advertisement. As implied in Section 2536.1(a), distinctly different levels of comprehension may be anticipated of the subscribers of various publications.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.2. Advertisements of Benefits Payable, Losses Covered or Premiums Payable.

(a) Deceptive Words, Phrases or Illustrations Prohibited.

(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

GUIDELINE 2536.2(a)(1)

This section prohibits words, phrases or illustrations which create deception to the reader by omission or commission. The following examples are illustrations of the prohibitions created by the Subsection:

1. An advertisement which describes any benefits that vary by age must disclose that fact.

2. An advertisement which uses a phrase such as "no age limit," if benefits or premiums vary by age or if age is an underwriting factor, must disclose that fact.

3. Advertisements, applications, requests for additional information and similar materials are unacceptable if they state or imply that the recipient has been individually selected to be offered insurance or has had his eligibility for such insurance individually determined in advance, when the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

4. Advertisements which indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population are acceptable risks, when such distinctions are not maintained in the issuance of policies, are not acceptable.

5. Advertisements for group or franchise group plans which provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless such is the fact.

6. It is unacceptable to use terms such as "enroll" or "join" to imply group or blanket insurance coverage when such is not the fact.

7. Any advertisement which contains statements such as "anyone can apply" or "anyone can join," other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer, is unacceptable.

8. An advertisement which states or implies immediate coverage or guaranteed issuance of a policy is unacceptable unless suitable administrative procedures exist so that the policy is issued within a reasonable period of time after the application is received by the insurer.

9. Any advertisement which uses any phrase or term such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a policy which is not a guaranteed issue policy is unacceptable unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

10. Applications, request forms for additional information and similar related materials are unacceptable if they resemble paper currency, bonds, stock certificates, etc.

11. No advertisement shall employ devices which are designed to create undue fear or anxiety in the minds of those to whom they are directed. Unacceptable examples of such devices are:

a) The use of phrases such as "cancer kills somebody every two minutes" and "total number of accidents" without reference to the total population from which such statistics are drawn. (As an example of a permissible device, data prepared by the American Cancer Society are acceptable provided their source is noted and they are not over–emphasized);

b) The use of phrases such as "the finest kind of treatment," implying that such treatment would be unavailable without insurance;

c) The reproduction of newspaper articles, etc., containing irrelevant facts and figures;

d) The use of illustrations which unduly emphasize automobile accidents, cripples or persons confined to beds who are in obvious distress or receiving hospital or medical bills or persons being evicted from their homes due to their hospital bills;

e) The use of phrases such as "financial disaster," "financial distress," "financial shock," or other phrases implying that financial ruin is likely without insurance where used in an advertisement which comes within Section 2536.2(a)(7) relating to policies covering specified illnesses or specified accidents only.

12. An advertisement which uses the word "plan" without identifying it as an "insurance plan" is not permissible.

13. An advertisement which implies in any manner that the prospective insured may realize a profit from obtaining hospital, medical or surgical insurance coverage is not acceptable.

14. An advertisement shall not state or imply by word, phrase or illustration that the benefits being offered will supplement any other insurance policy, insurance–type concept, or governmental plan if such is not the fact.

15. An advertisement of a hospital or other similar facility confinement benefit that makes reference to the benefit being paid directly to the policyholders is misleading unless, in making such a reference, the advertisement includes a statement that the benefits may be paid directly to the hospital or other health care facility if an assignment of benefits is made by the policyholders. An advertisement of medical and surgical expense benefits shall comply with this rule in regard to the disclosure of assignments of benefits to providers of services. Phrases such as "you collect," "you get paid," "pays you," or other words or phrases of similar import are acceptable so long as the advertisement indicates that benefits are payable to the insured or someone designated by the insured.

16. An advertisement which refers to "hospitalizations for injury or sickness" omitting the word "covered" when the policy excludes certain sicknesses or injuries is unacceptable. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sicknesses or injuries not covered is prominently set forth.

17. An advertisement which refers to "whenever you are hospitalized" or "while you are confined in the hospital" omitting the phrase "for covered injury or sickness," if the policy excludes certain injuries or sickness, is unacceptable. Continued reference to "covered injury or sickness" is not necessary where this fact has been prominently disclosed in the advertisement and where the description of sickness or injuries not covered is prominently set forth.

18. Advertisements which state that benefits are provided when "you" go to the hospital" are unacceptable unless the advertisement clearly sets forth the extent of the coverage.

19. An advertisement which fails to disclose that the definition of "hospital" does not include a nursing home, convalescent home or extended care facility, as the case may be, is unacceptable.

20. An advertisement which fails to disclose any waiting or elimination periods for specific benefits is unacceptable.

21. An advertisement for a limited policy, or a hospital indemnity policy, or a plan of insurance which covers only certain causes of loss (such as dread disease) or which covers only a certain type of loss (such as hospital confinement) is unacceptable if:

a) the advertisement refers to a total benefit maximum limit payable under the policy in any headline, lead-in or caption without also in the same headline, lead-in or caption specifying the applicable daily limits and other internal limits;

b) the advertisement states any total benefit limit without stating the periodic benefit payment, if any, and the length of time the periodic benefit would be payable to reach the total benefit limit;

c) the advertisement prominently displays a total benefit limit which would not, as a general rule, be payable under an average claim.

22. Advertisements which emphasize total amounts payable under hospital, medical or surgical coverage or other benefits in a policy, such as benefits for private duty nursing, are unacceptable unless the actual amounts payable per day for such indemnity or benefits are stated.

23. Examples of what benefits may be paid under a policy shall not disclose only maximum benefits unless such maximum benefits are paid for loss from common and probable illnesses or accidents rather than exceptional or rare illnesses or accidents or periods of confinement for such exceptional or rare accidents or illnesses.

24. When a range of benefit levels is set forth in an advertisement, it must be made clear that the insured will receive only the benefit level written or printed in the policy selected and issued. Language which implies that the insured may select the benefit level at the time of filing claims is unacceptable.

25. Language which implies that the amount of benefits payable under a loss-of-time policy may be increased at the time of claim or disability according to the needs of the insured is unacceptable.

26. An advertisement for loss-of-time coverage which is an invitation to contract and which sets forth a range of amounts of benefit levels is unacceptable unless it also states that eligibility for the benefits is based upon condition of health, income, other economic conditions, or other underwriting standards of the insurer if such is the fact.

27. The term "confining sickness" is an abbreviated expression and must be explained in an advertisement containing the term. Such an explanation might be as follows: "Benefits are payable for total disability due to confining sickness only so long as the insured is necessarily confined indoors." Captions such as "Lifetime Sickness Benefits" or "Five-Year Sickness Benefits" are incomplete if such benefits are subject to confinement requirements. When sickness benefits are subject to confinement requirements, captions such as "Lifetime House Confining Sickness Benefits" or "Five Year House Confining Sickness Benefits" would be permissible.

28. Advertisements for policies whose premiums are modest because of their limited coverage or limited amount of benefits shall not describe premiums as "low," "low cost," "budget" or use qualifying words of similar import. This rule also prohibits the use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain.

29. Advertisements which state or imply that premiums will not be changed in the future are not acceptable unless the advertised policies so provide.

30. An advertisement which does not require the premium to accompany the application must not over-emphasize the fact and must make the effective date of the coverage clear.

31. An advertisement which exaggerates the effect of statutorily mandated benefits or required policy provisions or which implies that such provisions are unique to the advertised policy is unacceptable. For example, the phrase, "Money Back Guarantee" is an exaggerated description of the ten-day right to examine the policy and is not acceptable.

32. An advertisement which implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough," or is otherwise unusual is acceptable. Also, the addition of a novel method of premium payment to an otherwise common plan of insurance does not render it "new."

33. An advertisement which is an invitation to contract and which fails to disclose the amount of any deductible and/or the percentage of any co-insurance factor is unacceptable.

34. An advertisement which fails to state clearly the type of insurance coverage being offered is not acceptable.

35. Language which states or implies that each member under a "family" contract is covered as to the maximum benefits advertised, where such is not the fact, is unacceptable.

36. The importance of diseases rarely or seldom found in the class of person to whom the policy is offered shall not be exaggerated in an advertisement.

37. A television, radio, mail or newspaper advertisement which is designed to produce leads either by use of a coupon or a request to write to the company or a subsequent advertisement prior to contact must include information disclosing that an agent may contact the applicant if such is the fact.

38. Advertisements for policies designed to supplement Medicare or which are otherwise designed for issue to the elderly shall not employ devices which are designed to create undue anxiety in the minds of such persons. Such phrases as "here is where most people over 65 learn about the gaps in Medicare" or "Medicare is great, but .." or which otherwise exaggerate the gaps in Medicare coverage are unacceptable. Phrases or devices which unduly excite fear and dependence upon relatives or charity are unacceptable. Phrases or devices which imply that long sicknesses or hospital stays are common among the elderly are unacceptable.

39. An advertisement implying that the coverage is supplemental to Medicare, if it does not explain the manner in which it is supplemental to Medicare coverage, is not acceptable.

40. An advertisement for a policy designed to supplement benefits under Medicare is unacceptable if the advertisement:

a) fails to disclose in clear language which of the Medicare benefits the policy is designed to supplement and which of the Medicare benefits the policy is not designed to supplement or if it otherwise implies that Medicare provides only those benefits which the policy is designed to supplement;

b) describes the in-patient hospital coverage of Medicare as "hospital Medicare" or "Medicare Part A" when the policy does not supplement the non-hospital or the psychiatric hospital benefits of Medicare Part A (phrases to the effect of "the in-hospital portion of Medicare Part A" are acceptable);

c) fails to clearly describe the operation of the Part or Parts of Medicare which the policy is designated to supplement;

d) describes those Medicare benefits not supplemented by the policy in such a way as to minimize their importance relative to the Medicare benefits which are supplemented;

e) prominently displays a total benefit limit which would not, as a general rule, be payable for an average claim;

f) fails to clearly describe the operation of the Medicare Part A "lifetime reserve" (currently 60 days) and initial "benefit period" (currently 90 days) or fails to state that Medicare Part A provides benefits for psychiatric hospital confinement, where the policy supplements Medicare Part A.

41. Advertisements which employ fictitious narratives are unacceptable; however, hypothetical claims may be used to illustrate the operation of the policies advertised.

(2) No advertisement shall contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (unless used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the term of the policy.

GUIDELINE 2536.2(a)(2)

This Subsection recognizes that certain words and phrases in advertising may have a tendency to mislead the public as to the extent of benefits under an advertised policy. Consequently, such terms (and those specified in the rule do not represent a comprehensive list but only examples) must be used with caution to avoid any tendency to exaggerate benefits and must not be used unless the statement is literally true in every instance. The use of the following phrases based on such terms or having the same effect must be similarly restricted: "pays hospital, surgical, etc., bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," "pays for fi-

nancial needs," "provides for replacement of your lost paycheck," "replaces income" or "emergency paycheck." Other phrases may or may not be acceptable depending upon the nature of the coverage being advertised. For example, the phrase "this policy will help to replace your income" is acceptable in advertising for loss-of-time coverage but is unacceptable in advertising for hospital confinement (including "hospital indemnity") coverage.

This rule also prohibits words or phrases which exaggerate the effect of benefit payment on the insured's general well-being, such as "worry-free savings plan," "guaranteed savings," "financial peace of mind" and "you will never have to worry about hospital bills again."

Advertisements for policies designed to supplement Medicare benefits are unacceptable if they fail to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period for which Medicare pays all hospital confinement expenses, currently 60 days, other than the initial deductible, if the policy so provides. The length of said period must be stated in days.

(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder," or stating "even pre-existing conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

GUIDELINE 2536.2(a)(3)

Explanations must not minimize nor describe restrictive provisions in a positive manner. Negative features must be accurately set forth. Any limitation on benefits excluding pre-existing conditions also must be restated under a caption concerning exclusions or limitations, notwithstanding that the pre-existing condition exclusion has been disclosed elsewhere in the advertisement. (See Guidelines for Section 2536.2(c) for additional comments on pre-existing conditions.)

(4) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

GUIDELINE 2536.2(a)(4)

The words, phrases, illustrations and concepts listed are illustrations of the words, phrases, illustrations and concepts prohibited by the Subsection which create the impression of a profit or gain to be realized by the insured when hospitalized.

Illustrations which depict paper currency or checks showing an amount payable are deceptive and misleading and are not permissible.

A hospital indemnity advertisement shall not include language such as "pay for a trip to Florida," "buy a new television" or otherwise imply that the insured will make profit on hospitalization.

An advertisement which uses words such as "extra," "special" or "added" to describe any benefit in the policy is unacceptable.

Although the Subsection prohibits the use of the phrase "tax free," it does not prohibit the use of complete and accurate terminology explaining the Internal Revenue Service rules applicable to the taxation of accident and sickness benefits. The IRS rules provide that the premiums paid for and the benefits received from hospital indemnity policies are subject to the same rules as loss of time premiums and benefits and are not afforded the same favorable tax treatment as premiums for expense incurred hospital, medical and surgical benefit coverages. (Currently, Rev. Rul. 68-451 and Rev. Rul. 69-154.) Prominence either by caption, lead-in, boldface or large type shall be given in any manner to any statements relating to the tax status of such benefits.

(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement unless such statements of such monthly or weekly benefit amounts are followed immediately by equally prominent statements of the benefit payable on a daily basis; for example, either of the following statements is acceptable: "$1,000.00 a Month ($33.33 a Day)" or "$33.33 a Day ($1,000.00 a Month)." When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(6) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

GUIDELINES 2536.2(a)(5) through 2536.2 (a)(7)

These Subsections are self-explanatory.

(8) An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan," or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

GUIDELINE 2536.2(a)(8)

This Subsection should be applied in conjunction with Section 2536.7.

Phrases such as "we cut costs to the bone" or "we deal direct with you so our costs are lower" shall not be used.

(b) Exceptions, Reductions and Limitations.

(1) When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

GUIDELINE 2536.2(b)(1)

The extent of disclosure required by this rule depends upon the type of advertisement. An institutional advertisement as defined in Section 2535.3(g) is not subject to this rule. An advertisement which is an invitation to inquire as defined in Section 2535.3(h) which mentions either the dollar amount of benefit payable and/or the period of time during which the benefit is payable must include a reference to the existence of exceptions, reductions and limitations in the manner required by Section 2535.3(h). An advertisement which is an invitation to contract as defined in Section 2535.3(i) must recite the exceptions, reductions and limitations as required by the rule and in a manner consistent with Section 2536.

If an exception, reduction or limitation is important enough to use in a policy, it is of sufficient importance that its existence in the policy should be referred to in the advertisement regardless of whether it may also be the subject matter of a provision of Insurance Code Sections 10350.1 through 10350.12 and 10369.2 through 10369.12.

Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy as to obscure the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner which does not minimize, render obscure or otherwise make them appear unimportant.

(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

GUIDELINE 2536.2(b)(2)

This Subsection imposes the same disclosure standards as the preceding paragraph with respect to policy provisions providing for waiting, elimination, probationary or similar time periods between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss. The comments under Subsection 2536.2(b)(1) are equally applicable to this Subsection. Where a policy has waiting, elimination, probationary or other such time periods, such provisions must be stated in negative terms. This requirement is comparable to that contemplated in Section 2536.2(a)(3) as to exceptions, reductions and limitations.

An advertisement for a policy designed to supplement Medicare benefits is unacceptable if it fails to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period, currently 60 days, for which Medicare pays all hospital confinement expenses other than the initial deductible, if the policy so provides. The length of said period must be stated in days.

(3) An advertisement shall not use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

GUIDELINE 2536.2(b)(3)

This Subsection is similar to Section 2536.2(a)(3) and requires a fair and accurate description of exceptions, limitations and reductions in a manner which does not minimize, render obscure or otherwise make them appear unimportant.

Advertisements must state exceptions, limitations and reductions in the negative and must not understate any exception, limitation or reduction or qualify any exception, limitation or reduction to emphasize coverage described elsewhere (i.e., "Does not pay for _____, however, Medicare pays this" is not acceptable, nor is "Does not pay for the first four days in hospital for sickness, but pays for accident from first day"). (Underscoring indicates the manner in which statements are sometimes emphasized.)

This Subsection prohibits the use of any term, such as "just," "only," "merely," "necessary" or "minimum" to describe any exclusion, limitation, reduction or exception.

(4) When a group disability income insurance policy contains provisions which reduce the amount of maximum benefit payable, any invitation to contract for the policy as defined in Subsection 2535.3(i) shall contain an example of how at least two common reductions would reduce the dollar amount of the maximum benefit that an insured would receive. This example shall be placed in the part of the invitation to contract in which the maximum benefit amount is described, and shall be as prominent as the maximum benefit amount. The example may be coupled with a disclaimer which explains that the example is for purposes of illustrating the effect of benefit reductions and is not intended to reflect the situation of a particular claimant under the policy.

GUIDELINE 2536.2(b)(4)

This Subsection is designed to ensure that insurers will better explain the effect of benefit reductions, sometimes known as "offsets," on the maximum benefit amounts set forth in their invitations to contract. It is not sufficient under subsection (4) to state the amount of the maximum benefit available under a policy without also showing, in a dollar amount example, how the maximum benefit amount might be reduced by at least two common reductions which are provided for in the policy. An example of how two common reductions would reduce the amount of the maximum benefit that an insured would receive is set forth below. The example assumes that the policy provides for a long term disability benefit payment of 60% of pre–disability earnings. This percentage may vary, depending on the terms of the policy.

Insured's monthly predisability earnings	$3,000
Long term disability benefit percentage	x 60%
Unreduced maximum benefit	$1,800
Less Social Security disability benefit per month	– 900
Less state disability income benefit per month	– 300
Amount of long term disability benefit per month	**$ 600**

(c) Pre–Existing Conditions.

(1) An advertisement which is subject to the requirements of Section 2536.2(b) shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The term "pre–existing condition" without an appropriate definition or description shall not be used.

GUIDELINE 2536.2(c)(1)

This Subsection imposes the same disclosure standards with respect to pre-existing conditions provisions as noted in Guideline 2536.2(b)(1). The comments under that Guideline are equally applicable to this Subsection of the rules since the pre–existing conditions provision is an exception under the rules.

This rule implements the objective of Section 2536.2(a)(3) by requiring in negative terms a description of the effect of a pre-existing condition exclusion because such an exclusion is a restriction on coverage. The subdivision also prohibits the use of the phrase "pre-existing condition" without an appropriate definition or description of the term and prohibits stating a reduction in the statutory time limit (such as a reduction from three years to two years or to one year) as an affirmative benefit. The words "appropriate definition or description" mean that the term "pre–existing condition" must be defined as it is used by the company's claims department.

(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specific policy, the advertisement, if it is an invitation to contract, shall disclose that a medical examination is required.

GUIDELINE 2535.2(c)(2)

The phrase "no health questions" or words of similar import shall not be used if the policy excludes pre–existing conditions.

Use of a phrase such as "guaranteed issue" or "automatic issue," if the policy excludes pre–existing conditions for a certain period, must be accompanied by a statement disclosing the fact in a manner which does not minimize, render obscure, or otherwise make it appear unimportant and is otherwise consistent with Section 2536.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre–existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

"Do you understand that this policy will not pay benefits during the first ___ year(s) after the issue date for a disease or physical condition which you now have or have had in the past?" [ ] YES;

Or substantially the following statement:

"I understand that the policy applied for will not pay benefits for any loss incurred during the first ___ year(s) after the issue date on account of disease or physical condition which I now have or have had in the past."

GUIDELINE 2536.2(c)(3)

This subsection is self–explanatory.

NOTE: Authority cited: Section 790.10, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, (1989) 48 Cal.3d 805; and *20th Century Ins. Co. v. Garamendi* (1994) 8 Cal.4th 216. Reference: Sections 790.02 and 790.03, Insurance Code.

HISTORY

1. Amendment filed 11–19–74; effective thirtieth day thereafter (Register 74, No. 48).
2. Amendment of Guideline 2536.2(b)(3), new Guideline 2536.2(b)(4) and new NOTE filed 6–24–2008; operative 8–23–2008 (Register 2008, No. 26).

§ 2536.3. Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination.

When an advertisement, which is an invitation to contract, refers to either a dollar amount or a period of time for which any benefit is payable,

or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

GUIDELINE 2536.3

This Section imposes the same disclosure standards with respect to policy provisions relating to renewability, cancellability and termination, modification of benefits, losses or premiums because of age or otherwise as stated in Guideline 2536.2(b)(1). The comments in that Guideline are equally applicable to this Section. Advertisements of cancellable policies must state that the contract is cancellable or renewable at the option of the company as the case may be. For example the following represent illustrations: A policy which is cancellable shall be advertised in a manner similar to "This policy can be cancelled by the company at any time." A policy which is renewable at the option of the insurance company shall be advertised in a manner similar to "This policy is renewable at the option of the company" or "The company has the right to refuse renewal of this policy" or "Renewable at the option of the insurer." Advertisements of such policies must indicate that the insurer has the right to increase premium rates.

With respect to non-cancellable policies and guaranteed renewable policies, the section requires a summary of the policy provisions with respect to renewability must be set forth and defined where appropriate. The disclosure of provisions relating to renewability requires the use of language such as "non-cancellable," "non-cancellable and guaranteed renewable," or "guaranteed renewable." The use of those terms and the definitions provided shall be consistent with Insurance Code Sections 10273 and 10273.3.

The Section also requires a statement of the qualifying conditions which constitute limitations on the permanent nature of the coverage. These customarily fall into three categories; (1) age limits, (2) reservation of a right to increase premiums and (3) the establishment of aggregate limits. For example, "non-cancellable and guaranteed renewable" does not fulfill the requirement of the section if the policy contains a terminal age of 65. In such a case, a proper statement would be "non-cancellable and guaranteed renewable to age 65." If a guaranteed renewable policy reserves the right to increase premiums, the statement must be expanded into language similar to "guaranteed renewable to age 65 but the Company reserves the right to increase premium rates on a class basis." If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase "subject to a maximum aggregate amount of $50,000" or similar language. A policy may have one or more than three basic limitations and an advertisement must describe each of those which the policy contains. Currently over 50% of new individual policy issues are guaranteed renewable, therefore, the fact that a policy is guaranteed renewable shall not be exaggerated.

This rule also requires the disclosure of any modification of benefits or losses covered because of age or for other reasons. Provisions for reduction of benefits at stated ages must be set forth. For example, a policy may contain a provision which reduces benefits 50% after age 60 although it is renewable to age 65. Such a reduction would have to be set forth. Also, a provision for the elimination of certain hazards at any specific ages or after the policy has been in force for a specified time would have to be set forth.

An advertisement for a policy which provides for step-rated premium rates based upon the policy year or the insured's attained age must disclose such rate increases and the times or ages at which such premiums increase.

This Section requires that the qualifying conditions of renewability must be disclosed in a manner which does not minimize or render obscure the qualifying conditions of renewal.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.4. Testimonials or Endorsements by Third Parties.

(a) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these regulations.

GUIDELINE 2536.4(a)

This Subsection must be applied in conjunction with Section 2536.5 and requires that all such statements must be genuine and not fictitious. Under this subsection, the manufacturing, substantive editing or "doctoring up" of a testimonial is clearly prohibited as being false and misleading to the insurance buying public. However, language which would be unacceptable under these rules must be edited out of a testimonial.

A testimonial must also represent the current opinion of the author. While an insurer is not required in each instance to check with the author each time the testimonial is used to ascertain that the views expressed have not altered, a testimonial should be checked before use in those instances when a change in views might be probable or reasonable to assume. When a testimonial is used more than one year after it was originally given, a confirmation must be obtained.

The Subsection does not prohibit testimonials of a general nature in which the author expresses appreciation for courteous treatment received or prompt payment of claims.

(b) If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement" or other words of similar import. This does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation. This subsection does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

GUIDELINE 2536.4(b)

This Subsection requires the disclosure of any financial interest of a person making a testimonial, endorsement or appraisal. Any payment, direct or indirect, whether specifically for the testimonial or endorsement or for any other services or relationship, is required to be disclosed. Reimbursement for substantial travel and entertainment expenses is also required to be disclosed; however, union scale wages required by union rules are not required to be disclosed. Travel away from the home of the person giving the testimonial or endorsement to a distant location involving transportation expenses, lodging expenses or expenses for meals constitutes payment and must be reflected as a paid endorsement. The requirement of disclosure may be fulfilled by use of the phrase "Paid Endorsement" or words of similar import in a type style and size that is identical to the endorser's name. In the case of television or radio advertising, the paid nature of the advertisement must be given prominence.

(c) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association or other organization, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

GUIDELINE 2536.4(c)

This Subsection requires both that approval or endorsement of a policy by an individual, group of individuals, society, association or other organization be factual and that any proprietary relationship between the sponsoring or endorsing organization and the insurer be disclosed. For example, if the dividend under an association group case is payable to the association, disclosure of that fact is required. Also, if the insurer or an officer of the insurer formed or controls the association, that fact must be disclosed.

(d) When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a peri-

od of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

GUIDELINE 2536.4(d)

This Subsection provides the Insurance Commissioner with the means to verify the authenticity of testimonials used in advertising efforts.

The use of testimonials which do not correctly reflect the present practices of the insurer or which are not applicable to the policy or benefit being advertised is not permissible.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.5. Use of Statistics.

(a) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

GUIDELINE 2536.5(a)

This Subsection prohibits the use of statistics in a manner which is misleading and deceptive. It requires the disclosure of all relevant facts and prohibits the use of irrelevant facts. An advertisement shall specifically identify the policy to which statistics relate and, where statistics are given which are applicable to a different policy, it must be stated clearly that the data do not relate to the policy being advertised.

Statistics which describe the insurer, such as assets, corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, must be used with extreme caution because of their

[The next page is 663.]

potential for misleading the public. As a specific example, an advertisement for a health insurance policy which refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

An advertisement which states the dollar amount of claims paid must also indicate the period over which such claims have been paid.

If the term "loss ratio" is used, it shall be properly explained in the context of the advertisement and, unless a regulation is subsequently issued otherwise defining the term, it shall be calculated on the basis of premiums earned to losses incurred and shall not be on a yearly run-off basis.

(b) An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

GUIDELINES 2536.5(b)

This Subsection prohibits deceptive or misleading statements in an advertisement regarding an insurer's claim settlement practices. It also prohibits the use of an unusual amount paid for a unique claim or an unusual claim whether actual or hypothetical.

(c) The source of any statistics used in an advertisement shall be identified in such advertisement.

GUIDELINE 2536.5(c)

This Subsection requires any advertisement which uses statistics to cite the source. The rule does not require that statistics for this State be used since such statistics as hospital charges and average stays may vary from state to state. When nationwide statistics are used such fact should be noted as such unless the statistics on the particular point are substantially the same as those for this State. Statistics may be used only if they are credible.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.6. Identification of Plan or Number of Policies.

(a) When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

(b) When an advertisement which is an invitation to contract refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

GUIDELINE 2536.6

This Section imposes the same disclosure standards as stated in Guideline 2536.2(b)(1). The comments in that Guideline are equally applicable to this Section.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.7. Disparaging Comparisons and Statements.

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

GUIDELINE 2536.7

This Section prohibits unfair or incomplete comparisons of products, insurers or business methods. It specifically prohibits comparisons of non-comparable policies and provides that advertisements shall not unfairly minimize nor disparage competing types of insurance coverages or competing methods of marketing insurance.

An advertisement should not contain statements such as "no red tape" or "here is all you do to receive benefits."

Advertisements which state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are unacceptable unless such exceptions, reductions or limitations are contained in a substantial majority of such competing coverages.

Advertisements which state or imply that an insurer's premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are unacceptable.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.8. Jurisdictional Licensing and Status of Insurer.

(a) An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

GUIDELINE 2536.8(a)

This Subsection prohibits advertisements which imply that an insurer is licensed beyond the limits of those jurisdictions where it is actually licensed. An advertisement which contains testimonials from persons who reside in a state in which the insurer is not licensed or which refers to claims of persons residing in states in which the insurer is not licensed implies licensing in those states and therefore is in violation of this rule unless the advertisement states that the insurer is not licensed in those states.

(b) An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government.

GUIDELINE 2536.8(b)

This Subsection prohibits advertisements implying that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of the state or federal governments. "Approval" of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, advertising or its financial condition.

Although the Subsection permits a reference to an insurer being licensed in a state where the advertisement appears, it does not allow exaggeration of the fact of such licensing nor does it permit the suggestion that competing insurers may not be so licensed because, in most states, an insurer must be licensed in the state to which it directs its advertising.

Terms such as "official," or words of similar import, used to describe any policy or application form are not permissible because of the potential for deceiving or misleading the public.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.9. Identity of Insurer.

(a) The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

(b) No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols, or physical materials used by agencies of the federal government or of this State, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

GUIDELINE 2536.9

This Section prohibits the use of an advertisement which has the capacity or tendency to mislead or deceive as to the true identity of the insurer. The section

recognizes the existence of holding companies. The requirement that the advertisement refer to the policy form number is applicable to individual and franchise policies only.

However, the requirement of the policy form number is not applicable to those advertisements for individual and franchise policies not required to disclose information under Sections 2536.2(b)(1) and (7). Subsection (a) and Subsection (b) prohibit misleading practices of insurers in connection with the sale of insurance to supplement Federal Medicare benefits and confusion by insurers with advertising material used by hospital service corporations or pre-paid health plans.

This Section prohibits advertisements, envelopes or stationery which employ words, letters, initials, symbols or other devices which are so similar to those used by governmental agencies or other insurers, including hospital service corporations and pre-paid health plans, that the public may be confused into believing:

(a) that the advertised coverages are somehow provided by or are endorsed by such governmental agencies or such other insurers;

(b) that the advertised coverages are the same as those provided by such governmental agencies or such other insurers;

(c) that the advertiser is the same as, is connected with or is endorsed by such governmental agencies or such other insurers.

It is unacceptable for an advertisement to use the name of a state or a political subdivision thereof in a policy name or description. For example, "XYZ Insurance Company's California Hospital Confinement Policy" is unacceptable.

This Section prohibits an insurer from using envelopes or stationery which have printed thereon any name, service mark, slogan, symbol or using any other device in such a manner that it implies that the insurer or the policy advertised is connected with a governmental agency such as the Social Security Administration or the Veterans Administration.

Policies advertised to supplement Medicare benefits are unacceptable if they incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, said word is qualified by language differentiating it from Medicare. Such phrases as "Medicare Insurance Supplement" or "insurance to supplement Medicare" are acceptable. Such an advertisement, however, shall not use the phrase" ___ Medicare Department of the XYZ Insurance Company," or language of similar import.

Advertisements for policies designed to supplement Medicare benefits are unacceptable if they fail to contain a disclaimer to the effect of "Not connected with or endorsed by the U.S. Government or the Federal Medicare program."

This section prohibits an advertisement which implies that the reader may lose a right, privilege or benefit under Federal, state or local law if he fails to respond to the advertisement.

If the use of letters, initials or symbols of the corporate name or trademark would have the capacity or tendency to mislead or deceive the public as to the true identity of the insurer, this Section prohibits the use of such letters, initials, or symbols without disclosing in a close conjunction the true and correct complete name of the insurer which will issue the policy.

This rule prohibits the use of the name of an agency or "___ Underwriters" or "___ Plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer and also prohibits an insurer from using an address so as to mislead or deceive as to its true identity, location or licensing status.

§ 2536.10. Group or Quasi-Group Implications.

An advertisement of a particular policy shall not state or imply that prospective insurers become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

GUIDELINE 2536.10

This Section prohibits the use of representations to any segment of the population that a particular policy or coverage is available only to that or similar segments of the population as preferred risks when actually such policy or coverage is available to members of the public at large at the same rates. This rule prohibits an advertisement labeled "Now for Readers of X Magazine."

This Section prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

HISTORY

1. Amendment filed 11-29-74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.11. Introductory, Initial or Special Offers.

(a)(1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising disability insurance.

GUIDELINE 2536.11(a)(1)

This Subsection prohibits advertising representing that a product is offered on an introductory, initial, special offer basis or otherwise which (a) will not be available later; or (b) is available only to certain individuals unless such is the fact. This rule prohibits the repetitive use of such advertisements. Where an insurer uses enrollment periods as the usual method of advertising these policies, the rule prohibits describing an enrollment period as a special opportunity or offer for the applicant.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within a specified geographical area in this State unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The phrase "a specified geographical area" means one or more of the following groups of counties:

(A) San Francisco, Marin, Sonoma, Napa, Solano, Alameda, Contra Costa and San Mateo,

(B) Sacramento, Amador, Alpine and North to the Oregon border,

(C) Santa Clara, Santa Cruz, San Benito and Monterey,

(D) San Joaquin, Stanislaus, Merced, Fresno, Kings, Kern and East to the Nevada border. Kern County may be included in either this Area (D) or in Area (E) below at the option of the insurer.

(E) San Luis Obispo, Santa Barbara and Ventura,

(F) Los Angeles, Orange, Riverside and San Bernardino,

(G) San Diego and Imperial.

The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, used by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or selected group (franchise) insurance.

GUIDELINE 2536.11(a)(2)

This Subsection restricts the repetitive use of enrollment periods. The requirement of reasonable closing dates and waiting periods between enrollment periods was adopted to eliminate the abuses which formerly existed. This rule does not limit just the use of enrollment periods. It requires that a particular insurance product offered in an enrollment period through any advertising media, including the prepared presentations of agents, cannot be offered again in a specified geographical area in this State until three months from the close of the enrollment period have expired. Thus, an insurer must choose whether to use enrollment periods or open enrollment for a product. (See Subsection 2536.11(a)(4) for definition of "a particular insurance product.")

This Subsection gives an insurer the option of applying the three month rule on a state-wide basis or on the basis of the geographical areas specified therein.

This Subsection does not prohibit multiple advertising during an enrollment period through any and all media published or transmitted within a specified geographical area in this state as long as the enrollment periods for all such advertisements have the same expiration date.

This Subsection does not prohibit the solicitation of members of a group or association for the same product even though there has not been a lapse of three months since the close of a preceding enrollment period which was open to the general public for the same product.

This Subsection does not require separation by three months of enrollment periods for the same insurance product in this state if the advertising material is directed by an admitted insurer to persons by direct mail on the basis that a common relationship exists with an entity, such as a bank and its depositors, a department store and its charge account customers or an oil company and its credit card holders, and more than one of such organizations is sponsoring such insurance product at different times if providing such insurance under such a method is not otherwise prohibited by law; provided, however, the three month rule does apply to one specific sponsor and the same persons in a specified geographical area in this state on the basis of their status as customers of that one specific entity only.

(3) This prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

GUIDELINE 2536.11(a)(3)

This Subsection is self–explanatory.

(4) The phrase "a particular insurance product" in subdivision (2) of this Section means an individual policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

GUIDELINE 2536.11(a)(4)

This Subsection defines the meaning of "a particular insurance product" in Section 2536.11(a)(2) and prohibits advertising of products having minor variations, such as different elimination periods or different amounts of daily hospital indemnity benefits, in a succession of enrollment periods.

(b) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

GUIDELINE 2536.11(b)

This Subsection prohibits advertising which overemphasizes an initial reduced premium. The rule requires the renewal premium to appear as frequently as, as prominently as and in juxtaposition with the initial reduced premium wherever and as often as it appears. The term "juxtaposition" means side by side or immediately above or below.

(c) Special awards, such as a "safe drivers' award" shall not be used in connection with advertisements of disability insurance.

GUIDELINE 2536.11(c)

This Subsection prohibits the use in advertisements of so-called awards as an inducement to the purchase of insurance.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2536.12. Statements About an Insurer.

An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

GUIDELINE 2536.12

This Subsection is closely related to the requirements of Section 2536.5 concerning the use of statistics. The Subsection prohibits insurers which have been organized for only a brief period of time advertising that they are "old" and also prohibits the use of illustrations of a "home office" building in a manner which is misleading with respect to the actual size and magnitude of the insurer. Also, the occupations of the persons comprising the insurer's board of directors or the public's familiarity with their names or reputations is irrelevant and must not be emphasized. The preponderance of a particular occupation or profession among the board of directors of an insurer does not justify the advertisement of a plan of insurance offered to the general public as insurance designed or recommended by members of that occupation or profession.

For example, it is unacceptable for an insurance company to advertise a policy offered to the general public as "The Physicians' Policy" or "The Doctors' Plan" simply because there is a preponderance of physicians or doctors on the board of directors of the insurer. The rule prohibits the use of a recommendation of a commercial rating system unless the purpose, meaning and limitations of the recommendation are clearly indicated.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2537. Enforcement Procedures.

(a) Advertising File: Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, selected group (franchise) and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

GUIDELINE 2537(a)

This Subsection is self–explanatory.

(b) Certificate of Compliance: Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these regulations must file with this Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, information and belief the advertisements of disability insurance which were disseminated by the insurer in this State during the preceding statement year complied or were made to comply in all respects with the provisions of these regulations and the Insurance Laws of this State as implemented and interpreted by these regulations.

GUIDELINE 2537(b)

Insurers become subject to the requirements of this Subsection by disseminating within this State advertisements of disability insurance which are not exempted from these regulations.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2537.1. Prior Inconsistent Regulations and Bulletins Superseded.

These regulations supersede all prior regulations and bulletins of this Department on the subject matter of disability insurance advertisements to the extent that such prior regulations and bulletins are inconsistent with these regulations. These regulations do not supersede Bulletin No. NS–3

issued by the Commissioner on May 18, 1956, except to the extent the Bulletin was applicable to disability insurance.

GUIDELINE 2537.1

This Section is self–explanatory.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

§ 2537.2. Severability Provision.

If any Section or portion of a Section of these regulations, or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulations, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

GUIDELINE 2537.2

This Section is self–explanatory.

HISTORY

1. Amendment filed 11–29–74; effective thirtieth day thereafter (Register 74, No. 48).

Article 12.1. Health Care Language Assistance Program

§ 2538.1. Authority and Purpose.

(a) These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of California Insurance Code sections 10133.8 and 10133.9 to establish standards and requirements to provide insureds, free of charge, with appropriate access to translated written materials and oral interpretation services in obtaining covered benefits. These regulations are applicable to all individual and group policies of health insurance and to all health insurers, as defined in section 106 of the California Insurance Code. Every health insurer shall comply with the requirements and standards established by Insurance Code sections 10133.8 and 10133.9 and these regulations.

(b) The purpose of these regulations is to accomplish maximum accessibility to language assistance services by limited English proficient insureds, including oral interpretation and written translation assistance and to set forth: a) the methods of surveying the language preferences and linguistic needs of insureds; b) the requirements, standards and quality assurance for translation of vital documents; c) the requirements, standards and quality assurance for individual access to oral interpretation services; and d) the reporting and data collection requirements for health insurers.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New article 12.1 (sections 2538.1–2538.8) and new section filed 9–19–2007; operative 10–19–2007 (Register 2007, No. 38).

§ 2538.2. Definitions.

For the purposes of these regulations, the following definitions apply:

(a) "Demographic profile" means, at a minimum, primary/preferred spoken and written language of insureds, race and ethnicity.

(b) "Indicated/threshold language(s)" means the language(s) identified by a health insurer pursuant to California Insurance Code section 10133.8 and these regulations into which vital documents shall be translated.

(c) "Individual access to interpretation services" means an insured's ability to receive oral interpretation services in their primary/preferred language in the provision of their health care.

(d) "Interpreting" or "interpretation" means the process of listening, understanding and analyzing something spoken or reading something written in one language (source language) and orally re–expressing that message faithfully, accurately and objectively in another spoken language (target language), taking the cultural and social context into account.

(e) "Language assistance services" means oral interpreting and written translation services provided free of charge to insureds.

(f) "Language preferences and linguistic needs assessment" means assessing and determining the spoken and written language preferences of the insured population.

(g) "Limited English Proficiency (LEP)" means a limited ability or inability to speak, read, write, or understand the English language at a level that permits the insured to interact effectively with his or her health care providers or health insurer.

(h) "Point(s) of Contact" means an instance in which an insured accesses the services covered under a health insurer's policy or certificate, including administrative and clinical services, telephonic and in–person contacts.

(i) "Remote interpreting" means interpreting provided by an interpreter who is not in the presence of the speaker, e.g., interpreting via telephone or videoconferencing.

(j) "Translating" or "translation" means the conversion of a written text in one language into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

(k) "Vital Documents" includes but is not limited to the following documents when produced by the health insurer including when the production or distribution is delegated by the health insurer to a third party:

(1) Applications;

(2) Consent forms, including health insurer authorization forms;

(3) Letters containing important information regarding eligibility and participation criteria;

(4) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a complaint or appeal;

(5) Notices advising LEP persons of the availability of free language assistance and other outreach materials that are provided to insureds;

(6) An insurer's explanation of benefits or claims processing information that is sent to an insured if the document requires a response from the insured;

(7) A matrix of the categories of health insurance benefits outlined in the insurance contract including co–payments and coinsurance, exclusions and limitations in the following sequence: deductibles; lifetime maximums; professional services; outpatient services; hospitalization services; diagnostic and therapeutic radiological services; preventive health services; emergency health care coverage including ambulance services; prescription drug coverage; durable medical equipment; mental health services; chemical dependency services; home health services; other services.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9–19–2007; operative 10–19–2007 (Register 2007, No. 38).

§ 2538.3. Language Assistance Program.

(a) By April 1, 2009, every health insurer shall have established and implemented a Language Assistance Program (LAP) that complies with the requirements of Insurance Code sections 10133.8 and 10133.9 and this regulation. The Commissioner shall allow health insurers a reasonable degree of flexibility in the methods by which they achieve compliance.

(b) The LAP shall be documented in a plan with comprehensive written policies and procedures that describe, at a minimum, the following elements: assessment of insureds; provision of language assistance services; staff training; and compliance monitoring. In addition, the policies and procedures shall include the following:

(1) How insureds will be informed of the availability of language assistance services at no charge to insureds and how to access those services;

(2) How contracting providers will be notified of the health insurer's LAP requirements for provision of language assistance services including the notice of the availability of language assistance services;

(3) How a survey of the language preferences and assessment of the linguistic needs of the insured population will be conducted including an explanation of the methodology for collection of relevant data;

(4) How vital documents will be translated into the indicated/threshold languages including standards to ensure the quality and accuracy of the written translation;

(5) How the insurer will provide individual access to interpretation services including an explanation of the standards to ensure the quality and timeliness of oral interpretation services;

(6) A training plan for the provision of adequate and ongoing training regarding the LAP for all health insurer staff who have contact with LEP persons. The training shall include instruction on, among other things, the health insurer's policies and procedures for accessing language assistance, working effectively with LEP persons, working effectively with in-person and telephonic interpreters, and, cultural differences among and diversity of the health insurer's insured population; and,

(7) How the insurer will evaluate the LAP including an analysis of complaints and satisfactions surveys.

(c) Every health insurer shall develop a written notice that discloses the availability of language assistance services to insureds and explains how to access those services.

(1) A copy of this notice shall be included with all vital documents and all new and renewing insured welcome packets or similar correspondence from the health insurer confirming a new or renewed enrollment. The notice of availability of translated vital documents shall be translated into the threshold languages; however, nothing in this section shall prohibit an insurer from translating the notice into additional languages. A written notice shall also advise LEP insureds of the availability of interpreter services in his/her preferred spoken language at all points of contact.

(2) The Commissioner may develop the notice advising LEP insureds of the availability of language assistance services. Insurer specific information regarding how to access those services shall be provided by the health insurer. If the notice is developed by the Commissioner, it shall reflect that access to oral interpretation services requires informing insureds of the availability of interpreter services in his/her preferred spoken language and that availability of translated vital documents requires informing insured in the threshold languages that vital documents are available in specifically identified threshold languages. Health insurers shall provide the Commissioner's notice to their insureds as specified in these regulations.

(d) Health insurers shall require compliance with their language assistance program developed pursuant to these regulations by every contractor, health care provider, and any network that is contracted to provide health care to insureds. Health insurers who directly contract with health care providers or who lease networks of health care providers shall use these contracts to implement the specific provisions of the health insurer's LAP, seeking amendments to such contracts as needed within a reasonable time of the effective date of these regulations. Health insurers shall retain financial responsibility for the implementation of the LAP except to the extent that delegated financial responsibility has been negotiated separately and incorporated by reference into its contract.

(e) By December 1, 2008, every health insurer shall file their LAPplan with the Commissioner, in accordance with sections 10133.8 and 10133.9 of the Insurance Code.

(1) The plan shall include but is not limited to the written LAP policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Insurance Code sections 10133.8 and 10133.9 and these regulations. The filing shall include the section 10133.8(b)(3)(B)(v) notice to insureds regarding the availability of language assistance services and how to access those services. All material filed with the Commissioner that contains documents in non-English languages shall include the English version of each non-English document as well as an attestation by the translator stating the qualifications of the translator and affirming that the non-English translation is an accurate translation of the English version.

(2) The Commissioner shall evaluate the totality of the health insurer's LAP to determine whether the program as a whole provides meaningful access for LEP insureds. This evaluation shall include a review of the information obtained from health insurer's biennial reporting to the Commissioner as required by these regulations and may consider relevant operational and demographic factors, including but not limited to:

(A) The nature of insureds points of contact;

(B) The frequency with which particular languages are encountered including specific challenges encountered in providing meaningful access and the process by which insurers address these challenges;

(C) The type of provider network or networks and methods of health care service delivery;

(D) The variations and character of a health insurer's service area;

(E) The availability of translation and interpretation services and professionals;

(F) The health insurer's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaboration with other health insurers to share a pool of interpreters, and other methods and technologies.

(3) The Commissioner shall periodically review health insurer compliance with the standards and requirements of section 10133.8 and 10133.9 of the Insurance Code and these regulations by methods that may include, but are not limited to, market conduct exams, reviews of consumer grievances and complaints and health provider complaints to the Department of Insurance. The Commissioner may also periodically request that health insurers submit information and data regarding insureds language needs and demographic profile.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9-19-2007; operative 10-19-2007 (Register 2007, No. 38).

§ 2538.4. Needs Assessment of Insured Population.

(a) Every health insurer shall survey the language preferences and assess the linguistic needs of insureds within one year of the effective date of these regulations. Health insurers may utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements of their insured population every three years.

(b) The LAP shall describe the health insurer's methods and timelines for surveying and assessing the language preferences and linguistic needs of the insured population, the calculations to be used to determine indicated/threshold languages, the method for collecting, summarizing and reporting the data to the Department, and how the health insurer shall advise limited English proficient insureds of the availability of translation and interpretation services.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9-19-2007; operative 10-19-2007 (Register 2007, No. 38).

§ 2538.5. Written Translation of Vital Documents.

(a) Every health insurer shall translate vital documents, as defined above, into languages other than English, hereinafter called "indicated/threshold languages" as follows:

(1) A health insurer with an insured population of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment and any additional languages when 0.75 percent or 15,000 of the insured population, whichever number is less, indicates in the needs assessment a preference for written materials in that language.

(2) A health insurer with an insured population of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment and any additional languages when 1 percent or 6,000 of the insured population,

whichever number is less, indicates in the needs assessment a preference for written materials in that language.

(3) A health insurer with an insured population of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or five percent of the insured population, whichever number is less, indicates in the needs assessment a preference for written materials in that language.

(b) For those vital documents that contain insured–specific information, health insurers shall provide the English language document together with the written notice of the availability of interpretation services and translation services in the indicated/threshold languages identified by the needs assessment.

(1) Upon request, the insured shall receive a written translation of the documents. The health insurer shall have 21 (twenty–one) days after receipt of the request to provide the written translation to the insured.

(2) Whenever a requested document requires that an insured take action within a certain period of time, that period of time shall not begin to elapse until the health insurer issues to the insured a translation of that document in accordance with the provisions of this article. For appeals that require expedited review and response, the health insurer may satisfy this requirement by providing the notice of the availability and access to oral interpretation services.

(c) Health insurers may request a phase–in of the translation of vital documents by submitting a written request to the Commissioner at the time of submission of their LAP plan. The request shall detail the plan, timeframe, rationale and projected impact of the phase–in on the receipt of culturally and linguistically competent health care by insureds. The translation of all vital documents shall be completed by the implementation date for the LAP as determined by these regulations.

(d) Every health insurer shall develop policies and procedures to ensure the quality and accuracy of written translations and that each translated document meets the same standards as are required for the English version of the document. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing translation services, including a documented and demonstrated proficiency in the source and target languages and knowledge of applicable specialized terminology in both the source and target languages.

(e) This section is not intended to prohibit or discourage a health insurer from providing translation of vital documents into a greater number of languages than the indicated/threshold languages.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9–19–2007; operative 10–19–2007 (Register 2007, No. 38).

§ 2538.6. Individual Access to Oral Interpretation Services.

(a) Every health insurer shall provide timely individual access to interpretation services at no cost to LEP insureds at all points of contact where language assistance is needed in accordance with these regulations. For purposes of this section, "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpreter services are not timely if delay results in the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in important rights, benefits, or services to the LEP insured.

(b) Every health insurer shall develop policies and procedures that describe the health insurer's methods for providing timely interpretation services, including, but not limited to the following:

(1) The points of contact where the need for interpreting may be reasonably anticipated;

(2) The types of resources necessary in order to provide effective interpreting to the health insurer's insureds;

(3) The arrangements that the health insurer will make to inform insureds of oral interpretation services and to provide timely access to interpreting at all points of contact at no charge to insureds;

(4) The range of interpreting services that will be provided by trained and competent individuals to insureds as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(A) Bilingual health insurer or contractor/health care provider staff available for the duration of the need;

(B) Hiring staff interpreters;

(C) Contracting with outside interpreters;

(D) Making volunteer interpreters available; and

(E) Contracting for remote interpreting, as defined, for an LEP person.

(c) Every health insurer shall develop policies and procedures for the use of family, friends, and minors as interpreters. The intent of these regulations is to provide qualified interpreting for all LEP insureds, in their primary/preferred spoken language, at no cost to the LEP insureds at all points of contact where language assistance is needed. It is the intent of these regulations to discourage the use of family members and friends and strongly discourage the use of minors as interpreters; however, nothing in this section is intended to create a barrier to care for LEP insureds.

(1) In a non–emergency situation, an insured may request the use of a family member or friend as the interpreter. Once the insured has requested the use of a family member or friend as his or her interpreter, the insured shall be fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the family member or friend as the interpreter shall be documented in the medical record file.

(2) In an emergency situation, a minor may be used as an interpreter if the following conditions are met:

(A) The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation; and,

(B) The insured is fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the minor as the interpreter shall be documented in the medical record file.

(d) Every health insurer shall develop policies and procedures to ensure the quality and timeliness of oral interpretation services provided to insureds. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing interpretation services, including a documented and demonstrated proficiency in the source and target languages, sensitivity to the LEP person's culture and a demonstrated ability to convey information accurately in both languages. A health insurer may develop and apply appropriate criteria for ensuring the proficiency of interpreter services. Criteria for interpreter ethics, conduct and qualifications adapted by the insurer from standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Health Care shall be accepted by the Commissioner.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9–19–2007; operative 10–19–2007 (Register 2007, No. 38).

§ 2538.7. Health Insurer Monitoring, Evaluation & Reporting.

(a) Every health insurer shall monitor the implementation and provision of its LAP and make modifications as necessary to ensure compliance with Insurance Code sections 10133.8 and 10133.9 and these regulations. The health insurer's policies and procedures shall include a description of the health insurer's method of (1) monitoring health insurer, contractor, health care provider, and network compliance with the health insurer's standards for the LAP Assistance Program, including the availability, quality and utilization of language assistance services, (2) tracking grievances and complaints related to its LAP Assistance Program, and (3) documenting actions taken to correct problems.

(b) Every health insurer shall evaluate the effectiveness of its LAP with regard to the following:

(1) Assessing indicated/threshold language(s) based on data collected;

(2) Assessing current language assistance needs of its insureds who are LEP persons;

(3) Documenting and responding to requests for translation and interpretation services;

(4) Whether the existing LAP Assistance Program meets the needs of its insureds who are LEP insureds;

(5) Whether health insurer staff know the health insurer's policies and procedures and how to implement them;

(6) Whether the resources and arrangements for language assistance identified in the health insurer's policies and procedures are still current and available; and

(7) Responding to communications from insureds, including via surveys and complaints.

(c) Every health insurer shall report the information and data requested by the Department of Insurance in a timely manner. Health insurers who do not report in a timely manner shall be subject to fines and penalties as authorized by the Insurance Code.

(1) By December 1, 2007, every health insurer shall report to the Department of Insurance on the status of the implementation of its LAP Assistance Program;

(2) Within one year after the health insurer's initial assessment but no later than December 1, 2009 and biennially by December 1st thereafter, every health insurer shall report to the Department of Insurance on its internal policies and procedures related to cultural appropriateness and any other information related to the health insurer's LAP as requested by the Commissioner, in a format specified by the department that shall include at least the following information:

(A) The data regarding the insured population based on the needs assessment as required by paragraph (2) of subdivision (b) of Insurance Code section 10133.8;

(B) The education of health insurer staff who have routine contact with insureds regarding the diverse needs of the insured population;

(C) The health insurer's recruitment and retention efforts that encourage workforce diversity;

(D) An evaluation of the health insurer's language assistance programs and services with respect to the health insurer's insured population, using processes such as an analysis of complaints and satisfaction survey results;

(E) The periodic provision of information regarding the ethnic diversity of the health insurer's insured population and any related strategies to health insurer's providers. Health insurers may use existing means of communication;

(F) The periodic provision of educational information to insureds on the health insurer's services and programs.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9–19–2007; operative 10–19–2007 (Register 2007, No. 38).

§ 2538.8. Department of Insurance Reporting.

Beginning on January 1, 2008, the Department shall report biennially to the Legislature regarding health insurer compliance with the standards established by Insurance Code section 10133.8 and these regulations including results of compliance audits made in conjunction with other audits and reviews. The Commissioner shall ensure that the reports required by this section as well as the data collected from health insurers for the reports do not require duplicative or conflicting data collection from health insurers. The Commissioner shall use the reported information from health insurers to make recommendations to health insurers for changes to their LAP, including the development of forms to notify insureds of their rights under these regulations and to further promote the purpose of these regulations.

NOTE: Authority cited: Sections 10133.8 and 10133.9, Insurance Code. Reference: Sections 10133.8 and 10133.9, Insurance Code.

HISTORY

1. New section filed 9–19–2007; operative 10–19–2007 (Register 2007, No. 38).

Article 12.2. Standard Supplemental Disclosure Forms for Disability Insurance

§ 2540. Authority.

This Article is promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Sections 790.10 and 10608 of the Insurance Code.

NOTE: Authority cited: Section 10608, Insurance Code.

HISTORY

1. New Article 12.2 (Sections 2540, 2540.1–2540.5) filed 4–10–75 as an emergency; designated effective 4–15–75 (Register 75, No. 15).
2. Certificate of Compliance filed 7–22–75 (Register 75, No. 30).
3. Amendment filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2)

§ 2540.1. Purpose.

The purpose of this Article is to establish standard supplemental disclosure forms for disability insurance as required by Chapter 7 of Part 2 of Division 2 of the Insurance Code, known as the "Health Insurance Disclosure Act of 1974." In enacting that Chapter, the Legislature declared that consumers seeking adequate health care insurance at prices they could afford were faced with considerable difficulty in making optimum choices among the great number of health care insurance coverages available. Confusing claims, obscure language and inconspicuous policy details often resulted in uniformed and inappropriate choices by the consumer. The availability of certain minimum information relative to the benefits, limitations and costs of health insurance coverages in a standard, readily comparable form would assist consumers in making the best choices among such insurance coverages commensurate with their respective incomes.

HISTORY

1. Amendment filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).

§ 2540.2. Definitions.

As used in this Article:

(a) "Policy" means any individual, family or selected group ("franchise") disability insurance policy and any individual or family benefit agreement issued by a non–profit hospital service plan.

(b) "Certificate" means any certificate of insurance issued pursuant to a blanket or group master disability insurance policy, any benefit certificate issued pursuant to a group benefit agreement issued by a non–profit hospital service plan and any document issued to an employee setting forth the details of disability coverage under any self–insured employee welfare plan.

HISTORY

1. Amendment filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).

§ 2540.3. Disclosure Forms for Use with Policies.

Supplemental disclosure forms for use with policies shall contain the text and shall be in the format of the prototype forms set forth in Section 2540.5 and shall contain no material of an advertising nature, except for the insurer's logotype. Such forms shall be plainly printed in no smaller than 11–point type. Text which is capitalized or underscored in the prototype forms may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring. Disclosure forms which are physically incorporated into advertisements shall not be intermingled with the text of such advertisements and shall be given prominence relative to that of surrounding text.

Where a policy is issued with benefits, exceptions, reductions, limitations, renewal provisions or premiums different from those in the policy as applied for, an amendment to the original disclosure form or a new disclosure form shall be delivered with the policy. Such amendment, together with the original disclosure form, or such new disclosure form shall properly describe the policy as issued and shall contain a statement, which shall be given prominence relative to that of surrounding text, to the following effect: "NOTICE: Read this outline of coverage carefully.

It is *not* identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued." Where the only difference between the policy as applied for and the policy as issued is the premium, the foregoing statement may be modified appropriately. An amendment to the disclosure form or a new disclosure form need not be delivered with the policy where modification of the policy features set forth above is effected by a rider to the policy which must be signed by the insured upon delivery of the policy.

HISTORY

1. Amendment filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).

§ 2540.4. Disclosure Forms for Use with Policies: Drafting Instructions.

Disclosure forms for use with policies shall be drafted in accordance with the following subsections, which refer to the paragraphs identified by bracketed numbers in the prototype disclosure forms set forth in Section 2540.5. Text in parentheses in the prototype forms may be varied as specified, except that the word "policy" may be replaced by an appropriate term such as "benefit agreement" where coverage is provided by a non–profit hospital service plan. Bracketed text in the prototype forms is instructional and need not appear in the forms as issued.

(a) Drafting Instructions for Paragraph [1]. The insurer's name may be substituted for the phrase, "your insurance company." This paragraph may be omitted from disclosure forms used with or incorporated into advertisements.

(b) Drafting Instructions for Paragraphs [2]. Each benefit enumerated in the prototype description of the category of coverage shall be stated, regardless of whether the policy with which the disclosure form is to be used provides that benefit. Unless provided otherwise, this paragraph may be omitted if the optional text appearing in parentheses in Paragraph [4] is used in that paragraph. This paragraph may also be omitted if no such optional text appears in Paragraph [4] of the appropriate prototype form.

(c) Drafting Instructions for Paragraph [3]. This paragraph shall set forth, in the order prescribed, a brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, provided by the policy with which the disclosure form is to be used. The description shall be stated clearly and concisely and shall include a description of any elimination periods, deductible amounts or co–payment requirements applicable to the benefits described. Where a benefit enumerated in this paragraph is not provided by the policy, it shall be listed with a notation to the effect that no coverage is provided therefor. Where the policy information required to be disclosed in this paragraph is variable at the option of the applicant, a disclosure form used with or incorporated into an advertisement may set forth the ranges over which such information may vary.

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(d) Drafting Instructions for Paragraph [4]. This paragraph shall set forth a description of any policy provisions which exclude, eliminate, restrict, reduce, limit or in any other manner operate to reduce or deny payment of the benefits described in Paragraph [3]. Limitations on coverage for pre–existing conditions and any Uniform Policy Provisions which may have the effect of reducing or denying payment of benefits shall be briefly described in this paragraph. Provisions which may have the effect of reducing benefits otherwise payable because of other coverage shall be briefly described in this paragraph. Where Paragraph [2] is omitted, the optional text, if any, appearing in parentheses in this paragraph shall be used in this paragraph.

(e) Drafting Instructions for Paragraph [5]. A description of policy provisions respecting renewability or continuation of coverage shall appear in this paragraph. Where coverage is provided by a non–profit hospital service plan, an appropriate phrase, such as "term of coverage," many be substituted for the word "renewability."

(f) Drafting Instructions for Paragraph [6]. The total premium payable by the insured for the coverage shall be stated in this paragraph. The mode of payment for the premium specified shall be prominently disclosed in conjunction with the premium. Initial policy fees may be stated separately, but recurring policy fees must be included within the total premium. If premiums are "step–rated," the premium for each step may be disclosed or the initial premium may be disclosed, accompanied by a statement to the effect of, "Renewal premiums for this policy will increase periodically depending upon (your age) (the policy year). Refer to the policy schedule for details." Unless a policy is issued with guaranteed premium rates, this paragraph must contain the statement, "Premiums are subject to change." Where coverage is provided by a non–profit hospital service plan, an appropriate phrase, such as "subscription charge," may be substituted for the word, "premium." Disclosure forms used with or incorporated into advertisements may refer to accompanying rate schedules in lieu of setting forth such schedules.

NOTE: Authority cited: Sections 10293(a) and 10608, Insurance Code.

HISTORY

1. Amendment filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).
2. Amendment of subsection (b) filed 4–5–78; designated effective 1–1–79 (Register 78, No. 14).

§ 2540.5. Prototype Standard Supplemental Disclosure Forms for Use with Policies.

(a) Policies which provide more than one category of coverage shall be accompanied by the disclosure form for the category of coverage most appropriate to the coverage provided. Benefits not included in the category selected shall be set forth in an orderly manner following the disclosure of the benefits included in the category selected. Where no prototype disclosure form is appropriate to the coverage provided, a disclosure form shall be used which is based, to the extent possible, upon the prototype forms set forth herein. Such disclosure form shall contain information relative to benefits, exceptions, reductions, limitations, renewability and premiums in the order set forth in the prototype forms and shall disclose such information in accordance with subsection (a) and subsections (c) through (f) of Section 2540.4, above.

(b) Prototype Standard Supplemental Disclosure Form for Policies Providing Basic Hospital Expense Coverage. "Basic Hospital Expense Coverage" provides benefits for expenses incurred for daily hospital room and board and miscellaneous hospital services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co–payment requirement.

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Basic Hospital Expense Coverage. This category of coverage is designed to provide to persons insured benefits for hospital expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and co–payment requirements set forth in the (policy). Benefits are not provided for physicians; or surgeons; fees or *unlimited* hospital expenses.

[3] Benefits of This (Policy).

(a) [Daily hospital room and board and benefit period;]

(b) [Miscellaneous hospital services;]

(c) [Hospital outpatient services;]

(d) [Other benefits, if any.]

[4] Exceptions, Reductions and Limitations of This (Policy).

(Benefits are not provided for physicians' or surgeons' fees.)

[5] (Renewability) of This (Policy).

[6] (Premium) for This (Policy).

(c) Prototype Standard Supplemental Disclosure Form for Policies Providing Basic Medical–Surgical Expense Coverage. "Basic Medical-Surgical Expense Coverage" provides benefits for expenses incurred for surgical, anesthesia and in–hospital medical services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co–payment requirement.

(COMPANY NAME)
BASIC MEDICAL–SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Basic Medical–Surgical Expense Coverage. This category of coverage is designed to provide to persons insured benefits for medical–surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for surgical services, anesthesia services, and in–hospital medical services, subject to any limitations, deductibles and co–payment requirements set forth in the (policy). Benefits are not provided for *unlimited* hospital expenses or medical–surgical expenses.

[3] Benefits of This (Policy).

(a) [Surgical services;]

(b) [Anesthesia services;]

(c) [In–hospital medical services;]

(d) [Other benefits, if any.]

[4] Exceptions, Reductions and Limitations of This (Policy).

(Benefits are not provided for hospital expenses)

[5] (Renewability) of This (Policy).

[6] (Premium) for This (Policy).

(d) Prototype Standard Supplemental Disclosure Form for Policies Providing Basic Hospital and Medical–Surgical Expense Coverage. "Basic Hospital and Medical–Surgical Coverage" provides benefits for expenses incurred for daily hospital room and board, miscellaneous hospital services, surgical, anesthesia and in–hospital medical services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co–payment requirement.

(COMPANY NAME)
BASIC HOSPITAL AND MEDICAL–SURGICAL EXPENSE
COVERAGE OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Basic Hospital and Medical–Surgical Expense Coverage. This category of coverage is designed to provide to persons insured benefits for hospital and medi-

cal–surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in—hospital medical services, subject to any limitations, deductibles and co–payment requirements set forth in the (policy). Benefits are not provided for *unlimited* hospital or medical–surgical expenses.

[3] Benefits of this (Policy)

(a) [Daily hospital room and board;]

(b) [Miscellaneous hospital services;]

(c) [Hospital outpatient services;]

(d) [Surgical services;]

(e) [Anesthesia services;]

(f) [In–hospital medical services;]

(g) [Other benefits, if any.]

[4] Exceptions, Reductions and Limitations of This (Policy).

[5] (Renewability) of This (Policy).

[6] (Premium) for This (Policy).

(e) Prototype Standard Supplemental Disclosure Form for Policies Providing Hospital Confinement Indemnity Coverage. "Hospital Confinement Indemnity Coverage" provides a stipulated daily benefit for hospital confinement as a result of covered accident or sickness. Benefits may be subject to elimination periods.

(COMPANY NAME)
HOSPITAL CONFINEMENT INDEMNITY
COVERAGE OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Hospital Confinement Indemnity Coverage. This category of coverage is designed to provide, to persons insured, a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the (policy). This coverage does not provide any benefits other than the fixed daily indemnity for hospital confinement. [The last sentence may be omitted or modified to reflect the benefits provided by the policy.]

[3] Benefits of This (Policy).

(a) [Daily benefit payable during hospital confinement and duration of such benefit;]

(b) [Elimination period, if any;]

(c) [Other benefits, if any.]

[4] Exceptions, Reductions and Limitations of This (Policy). (Benefits are not provided for physicians' or surgeons' fees nor for miscellaneous hospital services.) [The foregoing sentence may be modified to reflect the benefits provided by the policy.]

[5] (Renewability) of This (Policy).

[6] (Premiums for This (Policy).

(f) Prototype Standard Supplemental Disclosure Form for Policies Providing Major Medical Expense Coverage. "Major Medical Expense Coverage" provides benefits for major hospital, medical and surgical expenses incurred as a result of covered accident or sickness. Benefits are provided for daily hospital room and board, miscellaneous hospital services, surgical and anesthesia services, in–hospital medical services and prosthetic appliances, among other expenses. The maximum benefit for covered charges must at least equal $10,000. Benefits are subject to substantial fixed or variable deductibles, and may be subject to a co–payment requirement.

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Major Medical Expense Coverage. This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in–hospital medical services, out of hospital care, and prosthetic appliances, subject to any deductibles, co–payment provisions, or other limitations which may be set forth in the (policy). *Basic* hospital or *basic* medical insurance coverage is not provided.

[3] Benefits of This (Policy).

(a) [Daily hospital room and board;]

(b) [Miscellaneous hospital services;]

(c) [Surgical services;]

(d) [Anesthesia services;]

(e) [In–hospital medical services;]

(f) [Out–of–hospital care;]

(g) [Prosthetic appliances;]

(h) [Maximum dollar amount for covered charges;]

(i) [Other benefits, if any.]

[4] Exceptions, Reductions and Limitations of This (Policy). (This coverage does not provide *basic* hospital and medical coverage.)

[5] (Renewability) of This (Policy).

[6] (Premium) for This (Policy).

(g) Prototype Standard Supplemental Disclosure Form for Policies Providing Disability Income Protection Coverage. "Disability Income Protection provides benefits on account of the insured's inability, as a result of covered accident or sickness, to perform certain activities as defined in the policy.

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Disability Income Protection Coverage. This category of coverage is designed to provide, to persons insured, benefits for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the (policy). Benefits are not provided for basic hospital, basic medical–surgical, or major–medical expenses.

[3] Benefits of This (Policy). [The benefit description shall briefly describe the definition or definitions of total disability used in the policy. Benefit and elimination periods may be stated in the time units used in the policy.]

[4] Exceptions, Reductions and Limitations of This (Policy).

(No benefits are provided for hospital, medical or surgical expenses.) [The foregoing sentence may be omitted or modified to reflect the benefits provided by the policy.]

[5] (Renewability) of This (Policy).

[6] (Premium for This (Policy).

(h) Prototype Standard Supplemental Disclosure Form for Policies Providing Accident Only Coverage. "Accident Only Coverage" provides benefits of the nature specified in the policy for losses resulting to the insured from covered accidents. Any policy whose principal benefits are limited to accidental losses shall be included in this category, unless it falls within the following subsection. Benefits payable may vary according to accidental cause.

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Accident Only Coverage. This category of coverage is designed to provide, to persons insured, benefits for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the (policy). Benefits are not provided for basic hospital, basic medical–surgical, or major–medical expenses.

[3] Benefits of This (Policy). [Prototype disclosure forms for other types of coverage should be used as guides in drafting the benefit description, where appropriate. Where policy benefits vary according to accidental cause, this paragraph shall prominently set forth the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.]

[4] Exceptions, Reductions and Limitations of This (Policy). (No benefits are provided for any loss resulting from sickness.) [The foregoing sentence may be omitted or modified to reflect the benefits provided by the policy.]

[5] (Renewability) of This (Policy).

[6] (Premium for This (Policy).

(i) Prototype Standard Supplemental Disclosure Form for Policies Providing Specified Disease or Specified Accident Coverage.

"Specified Disease or Specified Accident Coverage" provides benefits of the nature specified in the policy only for losses resulting from the disease or type of accident specified in the policy.

(COMPANY NAME)
(SPECIFIED DISEASE)
(SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] (Specified Disease) (Specified Accident) Coverage. This category of coverage is designed to provide, to persons insured, benefits ONLY when certain losses occur as a result of (specified diseases) (specified accidents). Benefits are not provided for basic hospital, basic medical–surgical, or major–medical expenses.

[3] Benefits of This (Policy). [Prototype disclosure forms for other types of coverage should be used as guides in drafting the benefit description, where appropriate. Where specified accident policy benefits vary according to accidental cause, this paragraph shall prominently set forth the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.]

[4] Exceptions, Reductions and Limitations of This (Policy). (Benefits are not provided for losses caused by anything other than [specified diseases][specified accidents].)

[5] (Renewability) of This (Policy).

[6] (Premium for This (Policy).

(j) Prototype Standard Supplemental Disclosure Form for Policies Providing Comprehensive Major Medical Expense Coverage.

"Comprehensive Major Medical Expense Coverage" provides those benefits enumerated in subsection (f) of this section, except that coverage is not designed to supplement other coverage and may be subject only to modest fixed deductible amounts. Benefits may also be subject to a co–payment requirement.

(COMPANY NAME)
COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] Comprehensive Major Medical Expense Coverage. This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in–house medical services, out of hospital care, and prosthetic appliances, subject to any deductibles, co–payment provisions, or other limitations which may be set forth in the (policy).

[3] Benefits of This (Policy).

(a) [Daily hospital room and board;]

(b) [Miscellaneous hospital services;]

(c) [Surgical services;]

(d) [Anesthesia services;]

(e) [In–hospital medical services;]

(f) [Out–of–hospital care;]

(g) [Prosthetic appliances;]

(i) [Other benefits, if any.]

[4] Exceptions, Reductions and Limitations of This (Policy).

[5] (Renewability) of This (Policy).

[6] (Premium) for This (Policy).

(k) Disclosure Forms for Medicare Supplement Policies: Special Instructions. The name, address and telephone number of a representative of the insurer or the General Agent shall be inserted in the blank in the sentence following Paragraph (8). (Such representative may not be the agent, if any, who solicited or delivered the policy.) Such representative shall be located in this State unless a toll–free "800" telephone number is specified.

Insurers shall establish affirmative procedures for insuring that Medicare Supplement Policy Disclosure Forms are properly delivered pursuant to Insurance Code Sections 10601(e) and 10605, where solicitation is made on an other–than–direct response basis. Such procedures could include physically attaching disclosure forms to field–issued policies; requiring return to the insurer of copies of disclosure forms signed by prospective insureds; or requiring separately signed acknowledgments of receipt on application for insurance when such applications are returned to the insurer. (This requirement shall not be construed to mean that insurers need not establish reasonable procedures for insuring that other categories of disclosure forms are properly delivered to prospective insureds.)

(l) Prototype Standard Supplemental Disclosure Form for Policies Providing Medicare Supplement Coverage.

(COMPANY NAME)
MEDICARE SUPPLEMENT COVERAGE
OUTLINE OF COVERAGE

[1] Read Your (Policy) Carefully. This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you READ YOUR POLICY CAREFULLY!

[2] Medicare Supplement Coverage—Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital in–patient charges and some physician charges, subject to any deductibles and co–payment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

[3] (a) (For agents:) Neither (insert company's name) nor its agents are connected with Medicare.

(b) (For direct response:) (insert company's name) is not connected with Medicare.

[4] (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare Supplement Coverage in the following order:)

Service	*Benefit*	*Medicare pays*	*This Policy Pays*	*You Pay*
HOSPITALIZATION—Semiprivate room and board, general nursing and miscellaneous hospital services and supplies Includes meals,	First 60 days	All But $( )		
	61st to 90th day	All but $( ) a day		
special care units, drugs, lab tests, diagnostic X-rays, medical supplies,	90th to 150th day	All but $( ) a day		
operating and recovery room, anesthesia and rehabilitation services	Beyond 150 days	Nothing		
POST HOSPITAL SKILLED NURSING CARE—In a facility approved by	First 20 days	100% of costs		
Medicare you must have been in a hospital for at least	Additional 80 days	All but $( ) a day		
three days and enter the facility within 14 days after hospital discharge	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services in-patient and out-patient medical services and supplies at a hospital, physical and Speech therapy and ambulance.	80% of reasonable charge [after $( ) deductible]		

[5] (A statement that the policy does or does not cover the following:)

(a) Private duty nursing.

(b) Skilled nursing home care costs (beyond what is covered by Medicare).

(c) Custodial nursing home care costs.

(d) Intermediate nursing home care costs.

(e) Home health care (above number of visits covered by Medicare).

(f) Physician charges (above Medicare's reasonable charge).

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay).

(h) Care received outside of U.S.A.

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

[6] (A description of any policy provisions which excludes, eliminates, resists, reduces, limits, delays or in any other manner operates to qualify payment of the benefits described in (4) above, including conspicuous statements:)

(a) (That the chart summarizing Medicare benefits only briefly described such benefits.)

(b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitation.)

[7] (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of right to change premium.)

[8] (The amount of premium for this policy.)

If you have questions about this (policy), please write or call___.

NOTE: Authority cited: Sections 790.10, 10608 and 10195(g), Insurance Code. Reference: Sections 10195(g) and 10603, Insurance Code.

HISTORY

1. Amendment filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).
2. Amendment of subsections (e)(4), (h)(4), repealer and new subsection (k) and new subsections (l), (m) and (n) filed 4–5–78; designated effective 1–1–79 (Register 78, No. 14).
3. Repealer of subsections (k)–(n) and new subsections (k) and (l) filed 3–31–83; effective thirtieth day thereafter (Register 83, No. 14).

§ 2540.6. Standard Supplemental Disclosure Forms for Use with Certificates.

(a) Generally. Supplemental disclosure forms for use with certificates shall be in the format set forth below and shall contain no material of an advertising nature except for the logotype of the organization or organizations providing the coverage. Disclosure forms which are physically incorporated into certificates, advertisements or advance announcements of coverage shall not be intermingled with the text of such documents and shall be given prominence relative to that of surrounding text. Disclosure forms which are delivered with certificates shall appear on or be attached to the front cover or inside front pages of the certificates or they may precede the portions of the certificates which set forth the benefits subject to this Article. Disclosure forms for use with "blanket" coverages shall accompany certificates or memorandums of coverage if or when they are delivered to insurers, subscribers or employees.

(b) Drafting Instructions. Supplemental disclosure forms for use with certificates shall be plainly printed in no smaller than 11-point type and shall contain an appropriate caption or heading such as "Outline of Coverage." Such forms shall prominently state the organization or organizations providing the coverage and shall be introduced by a brief statement to the effect that the form is only a summary of the provisions of the certificate which, itself, must be consulted for the important details of the coverage provided. The information required to be disclosed by this section shall be set forth in separate provisions which shall be in the order set forth below. Each provision shall contain a caption or heading which reflects its subject matter.

(1) Categories of Coverage. The first provision shall state the category or categories of coverage provided by the certificate, selected from those defined in Section 2540.5, subsections (b) through (k), above.

(2) Benefits. The second provision shall briefly describe the benefits provided by the coverage or shall state the location or locations in the certificate where such benefits are disclosed. If benefits are set forth in the disclosure form, they shall be accompanied by disclosure of any elimination periods, deductible amounts or co-payment requirements applicable to the benefits described.

(3) Exceptions, Reductions and Limitations. The third provision shall briefly describe the exceptions, reductions and limitations to which the coverage is subject or shall state the location or locations in the certificate where such exceptions, reductions or limitations are described. Provisions which may have the effect of reducing benefits otherwise payable because of other coverage are deemed to be "reductions" for the purpose of this provision. Where exceptions, reductions and limitations are described in the certificate in conjunction with the description of benefits, this provision may contain a statement directing the covered person to refer to the benefit descriptions in the certificate.

(4) Continuation of Coverage. The fourth provision shall briefly describe the provisions in the certificate relating to eligibility for coverage and continuation and termination of coverage or shall state the location or locations of such provisions in the certificate.

(5) Premium or Contribution. The fifth provision shall disclose information relative to the premium or contribution paid by the insured, subscriber or employee for disability coverage. Where such premium or contribution is identifiable, its amount in effect at the time the disclosure form is delivered shall be disclosed. Alternatively, this provision may state where such information may be obtained (for example, statements of wages and deductions accompanying employee paychecks or premium notices). Where the premium or contribution for disability coverage is not identifiable because it is combined with the costs of other coverages not subject to this Article, this provision may be limited to a statement to the effect that the cost of the coverage is included within the premium or contribution paid by the insured, subscriber or employee for his benefit plan. This paragraph may be omitted if the coverage is provided without charge to the insured, subscriber or employee.

(c) Medicare Supplement Coverage. Supplemental disclosure forms for use with certificates providing Medicare supplement coverage as de-

fined in Section 2220.51 shall comply with Sections 2540.3 and 2540.5 in lieu of subsections (a) and (b) of this Section. Such disclosure forms may (1) use terms appropriate to group coverage in place of terms more appropriate to individual coverage and (2) may identify the master policyholder, but not so as to give more prominence to the master policyholder than to the insurer. Supplemental disclosure forms for use with combination certificates which provide comprehensive or major medical hospital, medical and surgical coverage to those under 65 and Medicare supplement coverage to those over age 65 are exempt from this subsection.

NOTE: Authority cited: Sections 790.10, 10195(g) and 10608, Insurance Code. Reference: Sections 10195 (g) and 10603, Insurance Code.

HISTORY

1. New section filed 1–8–76; effective thirtieth day thereafter (Register 76, No.2).
2. New subsection (c) filed 3–31–83; effective thirtieth day thereafter (Register 83, No. 14).

§ 2540.7. Prior Regulations Not Superseded.

This Article does not supersede Article 12 of this Subchapter or Article 1.5 of Subchapter 2 of this Title.

NOTE: Authority cited: Section 10608, Insurance Code. Reference: Section 10603, Insurance Code.

HISTORY

1. New section filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).

§ 2540.8. Severability.

If any Section or portion of a Section of this Article or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this Article, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

NOTE: Authority cited: Section 10608, Insurance Code. Reference: Section 10603, Insurance Code.

HISTORY

1. New section filed 1–8–76; effective thirtieth day thereafter (Register 76, No. 2).

Article 12.3. Valuation of Life Insurance Policies

§ 2542. Preamble.

Section 10489.94 of the California Insurance Code authorizes the commissioner to promulgate regulations to provide tables of select mortality factors and rules for their use, rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits, and rules concerning a minimum standard for the valuation of plans with secondary guarantees.

This Article 12.3 shall supersede Department of Insurance Bulletin Number 2000–02, effective July 1, 2000, issued by the commissioner under the authority of Section 10489.94 of the California Insurance Code.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Section 10489.94, Insurance Code.

HISTORY

1. New article 12.3 (sections 2542–2542.8) and section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

§ 2542.1. Purpose.

(a) The purpose of this article is to provide:

(1) Tables of select mortality factors and rules for their use;

(2) Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

(3) Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

(b) The method for calculating Basic Reserves defined in this article will constitute the commissioners reserve valuation method for policies to which this article is applicable.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Sections 10489.2, 10489.5 and 10489.94, Insurance Code.

HISTORY

1. New section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

§ 2542.2. Applicability.

This Article 12.3 shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this article, subject to the following exceptions and conditions.

(a) Exceptions

(1) This article shall not apply to any individual life insurance policy issued on or after the effective date of this article if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the effective date of this article, that guarantees the premium rates of the new policy. This article also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(2) This article shall not apply to any universal life policy that meets all the following requirements:

(A) Secondary guarantee period, if any, is five (5) years or less;

(B) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in Section 2542.3(f) and the applicable valuation interest rate; and

(C) The initial surrender charge is not less than 100 percent of the first year annualized specified premium for the secondary guarantee period.

(3) This article shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(4) This article shall not apply to any variable Universal Life Insurance Policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(5) This article shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(b) Conditions

(1) Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of Section 2542.5.

(2) Calculation of the minimum valuation standard for flexible premium and fixed premium Universal Life Insurance Policies that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period shall be in accordance with the provisions of Section 2542.6.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Section 10489.94, Insurance Code.

HISTORY

1. New section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

§ 2542.3. Definitions.

For purposes of this article:

(a) "Basic Reserves" means reserves calculated in accordance with California Insurance Code Section 10489.5.

(b) "Contract Segmentation Method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO Valuation Tables, as defined in Subdivision (f) of this Section 2542.3 (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for this purpose), and, if elected, the optional minimum mortality standard for Deficiency Reserves stipulated in Section 2542.4(b) of this article.

The length of a particular contract segment shall be set equal to the minimum of the value t for which G_t is greater than R_t (if G_t never exceeds

R_t the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

x = original issue age;

k = the number of years from the date of issue to the beginning of the segment;

t = 1, 2, ...; *t* is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = Guaranteed gross premium per thousand of face amount for year *t* of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$$

however, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one;

where:

x, k and t are as defined above, and

$q_{x+k+t-1}$ = valuation mortality rate per 1000 for Deficiency Reserves in policy year k+t but using the mortality of Section 2542.4(b)(2) if Section 2542.4(b)(3) is elected for Deficiency Reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

(c) "Deficiency Reserves" means the excess, if greater than zero, of

(1) Minimum reserves calculated in accordance with California Insurance Code Section 10489.9 over

(2) Basic Reserves.

(d) "Guaranteed Gross Premiums" means the premiums under a policy of life insurance that are guaranteed and determined at issue.

(e) "Maximum Valuation Interest Rates" means the interest rates defined in California Insurance Code Section 10489.4 (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies.

(f) "1980 CSO Valuation Tables" means the Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) (1981 *Transactions of the Society of Actuaries*, Volume 33, pp. 618, 673), without select factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law, and variations of the 1980 CSO Table approved by the NAIC and approved by regulation promulgated or bulletin issued by the commissioner. "1980 CSO Valuation Tables" includes the 1980 CSO Female Smoker and Non-smoker Mortality Rates, and the 1980 CSO Male Smoker and Non-smoker Mortality Rates, tables approved by the NAIC in December 1983 (1984 *Proceedings of the National Association of Insurance Commissioners*, I, pp. 406–407, 410–411), which tables are approved by the commissioner for purposes of this article. For valuation under this article of life insurance contracts issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment within the meaning of Subdivision (f) of Insurance Code Section 790.03, "1980 CSO Valuation Tables" also includes the Blended 1980 CSO Tables B through F, approved by the NAIC in December 1983 (1984 *Proceedings of the National Association of Insurance Commissioners*, I, pp. 396–400), which tables are approved by the commissioner for purposes of this article only for use with such contracts. The 1980 CSO Valuation Tables are hereby incorporated herein by reference.

(g) "Scheduled Gross Premium" means the smallest illustrated gross premium at issue for other than Universal Life Insurance Policies. For Universal Life Insurance Policies, Scheduled Gross Premium means the smallest specified premium described in Section 2542.6(a)(3), if any, or else the minimum premium described in Section 2542.6(a)(4).

(h)(1) "Segmented Reserves" means reserves, calculated using segments produced by the Contract Segmentation Method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective Guaranteed Gross Premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(A) The present value of the death benefits within the segment, plus

(B) The present value of any unusual guaranteed cash value (see Section 2542.5(d)) occurring at the end of the segment, less

(C) Any unusual guaranteed cash value occurring at the start of the segment, plus

(D) For the first segment only, the excess of Item 1. over Item 2., as follows:

1. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

2. A net one year term premium for the benefits provided for in the first policy year.

(2) The length of each segment is determined by the "Contract Segmentation Method," as defined in this Section 2542.3.

(3) The interest rates used in the present value calculations for any policy may not exceed the Maximum Valuation Interest Rates determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

(4) For both Basic Reserves and Deficiency Reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

(i) "Tabular Cost of Insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

(j) "Ten-year Select Factors" means the select factors (1981 *Transactions of the Society of Actuaries*, Volume 33, p. 669) adopted with the 1980 amendments to the NAIC Standard Valuation Law. The Ten-year Select Factors are hereby incorporated herein by reference.

(k)(1) "Unitary Reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

(A) Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

(B) Modified net premiums are a uniform percentage of the respective Guaranteed Gross Premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of Item 1. over Item 2., as follows:

1. A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

2. A net one year term premium for the benefits provided for in the first policy year.

(2) The interest rates used in the present value calculations for any policy may not exceed the Maximum Valuation Interest Rates determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

(*l*) "Universal Life Insurance Policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium

deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Sections 790.03, 10489.15, 10489.2, 10489.4, 10489.5, 10489.7, 10489.9 and 10489.94, Insurance Code.

HISTORY

1. New section filed 11-19-2002; operative 1-1-2003 (Register 2002, No. 47).

§ 2542.4. General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves.

(a) At the election of the company for any one or more specified plans of life insurance, the minimum mortality standard for Basic Reserves may be calculated using the 1980 CSO Valuation Tables, with or without select mortality factors (or any other valuation mortality table adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for this purpose). If select mortality factors are elected, they may be:

(1) The Ten-year Select Factors;

(2) The select mortality factors in Section 2542.8 of this article; or

(3) Any other table of select mortality factors adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for the purpose of calculating Basic Reserves.

(b) Deficiency Reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the Basic Reserve. The quantity A is obtained by recalculating the Basic Reserve for the policy using Guaranteed Gross Premiums instead of net premiums when the Guaranteed Gross Premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO Valuation Tables with or without select mortality factors (or any other valuation mortality table adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner). If select mortality factors are elected, they may be:

(1) The Ten-year Select Factors; or

(2) The select mortality factors in Section 2542.8 of this article, which may be modified as specified in Paragraph (3) below;

(3) For durations in the first segment, X percent of the select mortality factors in Section 2542.8, subject to the following:

(A) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(B) X shall not be less than twenty percent (20%);

(C) X shall not decrease in any successive policy years;

(D) X is such that, when using the valuation interest rate used for Basic Reserves, Item 1. below is greater than or equal to Item 2. below:

1. The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

2. The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

(E) X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date;

(F) The appointed actuary shall increase X at any valuation date where it is necessary in order to continue to meet all the requirements of this Paragraph (b)(3);

(G) The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of this Paragraph (b)(3); and

(H) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(I) If X is less than 100 percent at any duration for any policy, the requirements of Items 1. and 2. below shall be met:

1. The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of Article 17 of this Subchapter 3, as amended, commencing with Section 2580.1; and

2. The appointed actuary shall annually opine for all policies subject to this article as to whether the mortality rates resulting from the application of X meet the requirements of this Paragraph (b)(3). This opinion shall be supported by an actuarial report, subject to appropriate Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience; or

(4) Any other table of select mortality factors adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for the purpose of calculating deficiency reserves.

(c) This Subdivision (c) applies to both Basic Reserves and Deficiency Reserves. Any permissible set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten (10) years, the appropriate Ten-year Select Factors may be used thereafter through the tenth policy year from the date of issue.

(d) In determining Basic Reserves or Deficiency Reserves, Guaranteed Gross Premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining Deficiency Reserves, policy fees may be included in Guaranteed Gross Premiums, even if not included in the actual calculation of Basic Reserves.

(e) Reserves for policies that have changes to Guaranteed Gross Premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following: (1) reserves calculated ignoring the guarantee, (2) reserves assuming the guarantee was made at issue, and (3) reserves assuming that the policy was issued on the date of the guarantee.

(f) The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to the effective date of this article. This documentation may include a demonstration of the extent to which aggregation with other nonspecified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of Article 17 of this Subchapter 3, as amended, commencing with Section 2580.1.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Sections 790.03, 10489.15, 10489.2, 10489.5, 10489.7, 10489.9 and 10489.94, Insurance Code.

HISTORY

1. New section filed 11-19-2002; operative 1-1-2003 (Register 2002, No. 47).

§ 2542.5. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies).

(a) Basic Reserves. Basic Reserves shall be calculated as the greater of the Segmented Reserves and the Unitary Reserves. Both the Segmented Reserves and the Unitary Reserves for any policy shall use the same valuation mortality table and select factors. At the option of the insurer, in calculating Segmented Reserves and net premiums, either the adjustment described in Paragraph (1) below or the adjustment described in Paragraph (2) below may be made:

(1) Treat the Unitary Reserve, if greater than zero, applicable at the end of each segment as a pure endowment and subtract the Unitary Reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2) Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract

the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Deficiency Reserves

(1) The Deficiency Reserve at any duration shall be calculated:

(A) On a unitary basis if the corresponding basic reserve determined by Subdivision (a) of this Section 2542.5 is unitary;

(B) On a segmented basis if the corresponding basic reserve determined by Subdivision (a) of this Section 2542.5 is segmented; or

(C) On the segmented basis if the corresponding basic reserve determined by Subdivision (a) of this Section 2542.5 is equal to both the Segmented Reserve and the Unitary Reserve.

(2) This Subdivision (b) shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the Basic Reserves but using the minimum valuation standards of mortality (specified in Subdivision (b) of Section 2542.4) and rate of interest.

(3) Deficiency Reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in Subdivision (b) of Section 2542.4.

(4) For Deficiency Reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented Basic Reserves.

(c) Minimum Value. Basic Reserves may not be less than the Tabular Cost of Insurance for the balance of the policy year, if mean reserves are used. Basic Reserves may not be less than the Tabular Cost of Insurance for the balance of the current modal period or to the paid–to date, if later, but not beyond the next policy anniversary, if mid–terminal reserves are used. The Tabular Cost of Insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the Segmented Reserves. However, if select mortality factors are used, they shall be the Ten–year Select Factors. In no case may total reserves (including Basic Reserves, Deficiency Reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

(d) Unusual Pattern of Guaranteed Cash Surrender Values

(1) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where *n* is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(2) The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an *n* year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where

(A) *n* is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

1. The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

2. The mandatory expiration date of the policy; and

(B) The net premium for a given year during the *n* year period is equal to the product of the net to gross ratio and the respective gross premium; and

(C) The net to gross ratio is equal to Item 1. divided by Item 2. as follows:

1. The present value, at the beginning of the *n* year period, of death benefits payable during the *n* year period plus the present value, at the beginning of the *n* year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the *n* year period.

2. The present value, at the beginning of the *n* year period, of the Scheduled Gross Premiums payable during the *n* year period.

(3) For purposes of this Subdivision (d), a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(A) One hundred ten percent (110%) of the Scheduled Gross Premium for that year;

(B) One hundred ten percent (110%) of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the Scheduled Gross Premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(C) Five percent (5%) of the first policy year surrender charge, if any.

(e) Optional Exemption for Yearly Renewable Term (YRT) Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used:

(1) Calculate the valuation net premium for each future policy year as the Tabular Cost of Insurance for that future year.

(2) Basic Reserves shall never be less than the Tabular Cost of Insurance for the appropriate period, as defined in Subdivision (c) of this Section 2542.5.

(3) Deficiency Reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency Reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (e)(3)(A) above.

(4) For purposes of this Subdivision (e), the calculations use the Maximum Valuation Interest Rate and the 1980 CSO Valuation Tables with or without Ten–year Select Factors, or any other table adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for this purpose.

(5) A reinsurance agreement shall be considered YRT reinsurance for purposes of this Subdivision (e) if only the mortality risk is reinsured.

(6) If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

(f) Optional Exemption for Attained–Age–Based Yearly Renewable Term Life Insurance Policies. At the election of the company, the following approach for reserves for attained–age–based YRT life insurance policies may be used:

(1) Calculate the valuation net premium for each future policy year as the Tabular Cost of Insurance for that future year.

(2) Basic Reserves shall never be less than the Tabular Cost of Insurance for the appropriate period, as defined in Subdivision (c) of this Section 2542.5.

(3) Deficiency Reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency Reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with Subparagraph (A) above.

(4) For purposes of this Subdivision (f), the calculations use the Maximum Valuation Interest Rate and the 1980 CSO Valuation Tables with or without Ten–year Select Factors, or any other table adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for this purpose.

(5) A policy shall be considered an attained–age–based YRT life insurance policy for purposes of this Subdivision (f) if:

(A) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age

of the insured such that the rate for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(B) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

(6) For policies that become attained–age–based YRT policies after an initial period of coverage, the approach of this Subdivision (f) may be used after the initial period if:

(A) After the initial period of coverage, the policy meets the conditions of Paragraph (5) above; and

(B) The conditions of either Item 1. or Item 2. below are satisfied:

1. The initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; or

2. The initial period is constant for all insureds of the same sex, risk class and plan of insurance.

(7) If this election is made, this approach shall be applied in determining reserves for all attained–age–based YRT life insurance policies issued on or after the effective date of this article.

(g) Exemption from Unitary Reserves for Certain *n*–Year Renewable Term Life Insurance Polices. Unitary Basic Reserves and unitary Deficiency Reserves need not be calculated for a policy if the following conditions are met:

(1) The policy consists of a series of *n*–year periods, including the first period and all renewal periods, where *n* is the same for each period, except that for the final renewal period, *n* may be truncated or extended to reach the expiry age, provided that this final renewal period is less than 10 years and less than twice the length of the earlier *n*–year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(2) The Guaranteed Gross Premiums in all *n*–year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without Ten–year Select Factors; and

(3) There are no cash surrender values in any policy year.

(h) Exemption from Unitary Reserves for Certain Juvenile Policies. Unitary Basic Reserves and unitary Deficiency Reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

(1) At issue, the insured is age twenty–four (24) or younger;

(2) Until the insured reaches the end of the juvenile period, which shall occur at or before age twenty–five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and

(3) After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Sections 790.03, 10489.15, 10489.2, 10489.4, 10489.5, 10489.7, 10489.9 and 10489.94, Insurance Code.

HISTORY

1. New section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

§ 2542.6. Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies that Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period.

(a) General

(1) Policies with a secondary guarantee include:

(A) A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums;

(B) A policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the *Maximum Valuation Interest Rates and the 1980 CSO Valuation Tables* with or without Ten–year Select Factors, or any other table adopted by the NAIC after July 1, 2000 and approved by regulation promulgated or bulletin issued by the commissioner for this purpose; or

(C) A policy with any combination of Subparagraphs (a)(1)(A) and (a)(1)(B) above.

(2) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in Subdivisions (b) and (c) below shall be recalculated from issue to reflect these changes.

(3) Specified premiums are the premiums specified in the policy, the payment of which guarantees that the policy will remain in force for a secondary guarantee period at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed. Specified premiums may be stated directly or implied. For example, specified premiums may be implied via a guarantee that the policy will not lapse if the accumulation of premiums less withdrawals as of any given date exceeds a certain dollar amount. Such accumulation may or may not reflect interest and/or deductions for cost of insurance or expense.

(4) For purposes of this Section 2542.6, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate which are all guaranteed at issue.

(5) The one–year valuation premium is the net one–year premium based upon the original schedule of benefits for a given policy year. The one–year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in Paragraphs (b)(2), (b)(3) or (b)(4) of Section 2542.4 may not be used to calculate the one–year valuation premiums.

(6) The one–year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(b) Basic Reserves for the Secondary Guarantees. Basic Reserves for the secondary guarantees shall be the Segmented Reserves for the secondary guarantee period. In calculating the segments and the Segmented Reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the Contract Segmentation Method as defined in Section 2542.3(b). Any contract provision guaranteeing that the death benefit will be kept in force even when the policy account or cash value is zero must be valued consistently with the principles underlying this article.

(c) Deficiency Reserves for the Secondary Guarantees. Deficiency Reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in Section 2542.5(b) with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force.

(d) Recognition of Actual Premiums Paid. If the accumulation of actual premiums paid up through the valuation date is a factor in determining the amount of future premiums necessary to satisfy the secondary guarantee requirement, then the Basic and Deficiency Reserves must be adjusted to reflect this factor.

(e) Minimum Reserves. The minimum reserves during the secondary guarantee period are the greater of:

(1) The Basic Reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(2) The minimum reserves required by other rules or regulations governing universal life plans.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Sections 790.03, 10489.15, 10489.2, 10489.4, 10489.5, 10489.7 and 10489.94, Insurance Code.

HISTORY

1. New section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

§ 2542.7. Effective Date.

This article shall become effective January 1, 2003.

NOTE: Authority cited: Section 10489.94, Insurance Code. Reference: Section 10489.94, Insurance Code.

HISTORY

1. New section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

§ 2542.8. Select Mortality Factors.

This Section 2542.8 contains tables of select mortality factors that are the bases to which the respective percentages of Paragraph (b)(3) of Section 2542.4 are applied.

The six tables of select mortality factors contained herein include: (1) male aggregate, (2) male nonsmoker, (3) male smoker, (4) female aggregate, (5) female nonsmoker, and (6) female smoker.

These tables apply to both age last birthday and age nearest birthday mortality tables.

For sex–blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for Table B of the Blended 1980 CSO Tables, the calculated select mortality factors are eighty percent (80%) of the appropriate male table in this Section 2542.8, plus twenty percent (20%) of the appropriate female table in this Section 2542.8.

NOTE: Authority cited: Sections 10489.2 and 10489.94, Insurance Code. Reference: Sections 790.03, 10489.2 and 10489.94, Insurance Code.

HISTORY

1. New section filed 11–19–2002; operative 1–1–2003 (Register 2002, No. 47).

SELECT MORTALITY FACTORS

Male, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100

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53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	39	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SELECT MORTALITY FACTORS

Male, Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100

3

51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SELECT MORTALITY FACTORS

Male, Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	80	81	85	89	92	96	100
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100

49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SELECT MORTALITY FACTORS

Female, Aggregate																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100

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49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SELECT MORTALITY FACTORS

Female, Non-Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100

51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SELECT MORTALITY FACTORS

Female, Smoker																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100

51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Article 12.4. Valuation of Universal Life Insurance Policies

§ 2544. Preamble.

Section 10489.10 of the California Insurance Code authorizes the Commissioner to promulgate regulations concerning minimum reserves in the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in Sections 10489.5, 10489.6 and 10489.9. Universal life insurance plans come within the category of plans defined by Section 10489.10.

The purpose of these regulations is to delineate certain methods for determining minimum reserves specifically applicable to universal life insurance policies in accordance with California Insurance Code Section 10489.10.

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2544.1. Effective Date.

All insurance companies authorized to write life insurance in the State of California shall set up reserves on Universal Life Insurance Policies according to the specifications set forth in these regulations. These specifications will be effective for all policies issued after December 31, 1991.

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2544.2. Definitions.

As used in these regulations:

(a) "Universal Life Insurance Policy" means any individual or group life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges for the cost of benefits provided by rider;

(b) "Flexible Premium Universal Life Insurance Policy" means a universal life insurance policy which permits the policyowner to vary, independently of each other, the amount or timing of one or more premium payments or the amount of insurance;

(c) "Fixed Premium Universal Life Insurance Policy" means a universal life insurance policy other than a flexible premium universal life insurance policy;

(d) "Net Cash Surrender Value" means the maximum amount payable to the policyowner upon surrender;

(e) "Cash Surrender Value" means the net cash surrender value plus any amounts outstanding as policy loans;

(f) "Policy Value" means the amount to which separately identifiable interest credits and mortality, expense, or other charges are made under a universal life insurance policy.

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2544.3. Reserve Requirements.

(a) The minimum valuation standard for universal life insurance policies shall be the Commissioner's Reserve Valuation Method, as described below for such policies, and the tables and interest rates specified below. The terminal reserve for the basic policy, and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary, shall be equal to the net level premium reserves less S and less T, as hereinafter specified:

The net level premium reserve shall be equal to [Q – R] r where Q, R and r are as defined below:

(1) Q is the present value of all future guaranteed benefits at the date of valuation;

(2) R is the quantity (PVFB/äx) (äx+t), where:

(A) PVFB is the present value of all benefits guaranteed at issue assuming future Guaranteed Maturity Premiums as defined below are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer; and,

(B) äx and äx+t are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and x+t respectively, and continuing until the highest attained age at which a premium may be paid under the policy;

(3) r is equal to one, unless the policy is a flexible premium policy and the policy value is less than the Guaranteed Maturity Fund, in which case r is the ratio of the policy value to the Guaranteed Maturity Fund;

(4) The Guaranteed Maturity Fund at any duration is that amount which, together with future Guaranteed Maturity Premiums, will mature the policy based on all policy guarantees at issue;

(5) The Guaranteed Maturity Premium for flexible premium universal life insurance policies shall be that level gross premium, paid at issue and periodically thereafter over the period during which premiums are allowed to be paid, which will mature the policy on the latest maturity date, if any, permitted under the policy (otherwise at the highest age in the valuation mortality table), for an amount which is in accordance with the policy structure. The Guaranteed Maturity Premium is calculated at issue based on all policy guarantees at issue (excluding guarantees linked to an external referent);

(6) The Guaranteed Maturity Premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees;

(7) The maturity amount shall be the initial death benefit where the death benefit is level over the lifetime of the policy except for the existence of a minimum–death–benefit corridor, or, shall be the specified amount where the death benefit equals a specified amount plus the policy value or cash surrender value except for the existence of a minimum–death–benefit corridor;

(8) The death benefit corridor is defined by the minimum death benefit payable under the terms of the policy;

(9) The Guaranteed Maturity Premium for both flexible and fixed premium policies shall be adjusted for death benefit corridors provided by the policy. The Guaranteed Maturity Premium may be less than the premium necessary to pay all charges. This can especially happen in the first year for policies with large first year expense charges;

(10) S is the quantity [(a)–(b)]x (äx+t/äx)r where (a)–(b) is as described in Section 10489.5 of the California Insurance Code for the plan of insurance defined at issue by the Guaranteed Maturity Premiums and all guarantees contained in the policy or declared by the insurer. [äx and äx+t are defined in (2) (B) above];

(11) T is the sum of any additional quantities analogous to S which arise because of structural changes in the policy, with each such quantity being determined on a basis consistent with that of S using the maturity date in effect at the time of the change;

(A) Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyowner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period. For fixed premium universal life policies with redetermination of all credits and charges no more frequently that annually, on policy anniversaries, structural changes also include changes in guaranteed benefits, or in fixed premiums, unanticipated by the guaranteed maturity premium for such policies at the date of issue, even if such changes arise

from automatic workings of the policy. The computation of R above, for fixed premium universal life structural changes shall exclude from the present value of future guaranteed benefits those guaranteed benefits which are funded by the excess of the insurer's declared guarantees of interest, mortality and expenses, over the guarantees contained in the policy at the date of issue.

(B) In effecting structural changes, consistent methods shall be used to calculate reserves. Such methods may include that of maintaining proportionality between the Guaranteed Maturity Fund and Guaranteed Maturity Premium. Values may be calculated per dollar of face amount and multiplied by the new face amount. This method eliminates much of the complexity involved in other methods.

(b) The Guaranteed Maturity Premium, the Guaranteed Maturity Fund and R above shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the descriptions above.

(c) Future guaranteed benefits shall be determined by:

(1) Projecting the greater of the Guaranteed Maturity Fund and the policy value, taking into account future Guaranteed Maturity Premiums, if any, and using all guarantees of interest, mortality, expense deductions, or other guarantees contained in the policy or declared by the insurer; and,

(2) Taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

(d) All present values shall be determined using:

(1) The lesser of the interest rate (or rates) specified by Section 10489.4 of the California Insurance Code for the calculation of minimum reserve values on policies issued in the same year, or the guaranteed accumulation rate (or rates) of interest specified by the policy form; and,

(2) The statutory mortality rates specified in the policy as required by Section 10160(e) of the California Insurance Code.

(e) As an approximation and a simplification and in lieu of the methods described in this section, a company may use the mean of the cash surrender value and the policy value as the reserve. This shall be known as the California method. Upon request and with approval of the Commissioner, a company may use this method on all its universal life business it issues before as well as after December 31, 1991.

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2544.4. Alternate Minimum Reserves.

If, in any policy year, the Guaranteed Maturity Premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of subparts (1) or (2) of this section:

(1) The reserve calculated according to the method, the mortality table, and the rate of interest actually used; or,

(2) The reserve calculated according to the method actually used, but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the Guaranteed Maturity Premium in each policy year for which the valuation net premium exceeds the Guaranteed Maturity Premium.

For universal life reserves on a net level premium basis, the valuation net premium shall be PVFB/äx and for reserves on a Commissioners Reserve Valuation Method, the valuation net premium shall be $(PVFB/\ddot{a}_x) + ([(a)-(b)]/\ddot{a}_x)$.

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2544.5. Excess Interest Guarantee Reserves.

In the event a guarantee of interest greater than the maximum valuation interest rate permitted by Section 10489.4 of the California Insurance Code extends more than one year beyond the policy anniversary date previous to the date of valuation, the greatest of the present values of future guaranteed cash values and death benefits payable less required future premiums will be determined at the date of valuation using such maximum valuation interest rate (or rates) for policies issued in the same year as the year of issue of the policy valued and the mortality rates specified by Section 10489.2 of the California Insurance Code. The minimum reserve shall be the greatest of the values calculated in accordance with Sections 2544.3, 2544.4 or 2544.5 of this Regulation.

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2544.6. Scope.

These regulations are applicable to all individual and group universal life insurance policies except variable life insurance (covered by Bulletin 87–3).

NOTE: Authority cited: Sections 790.10, 10489.10, 12921 and 12926, California Insurance Code. Reference: Section 10489.10, California Insurance Code.

HISTORY

1. New section filed 10–17–91; operative 11–18–91 (Register 92, No. 3).

§ 2545. Authority.

NOTE: Authority cited: Section 790.10, Insurance Code.

HISTORY

1. New article 12.5 (Sections 2545, 2545.1–2545.5) filed 7–17–94; effective thirtieth day thereafter (Register 74, No. 29).
2. Amendment of article title filed 6–9–78; effective thirtieth day thereafter (Register 78, No. 23).
3. Repealer of article 12.5 and section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

§ 2545.1. Purpose.

HISTORY

1. Repealer filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

§ 2545.2. Disclosure Requirements.

HISTORY

1. Amendment filed 6–7–78; effective thirtieth day thereafter (Register 78, No. 23).
2. Repealer filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

§ 2545.3. Life Insurance Surrender Cost Index Defined.

HISTORY

1. Amendment filed 6–9–78; effective thirtieth day thereafter (Register 78, No. 23).
2. Repealer filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

§ 2545.4. Limitations.

HISTORY

1. Amendment filed 6–9–78; effective thirtieth day thereafter (Register 78, No. 23).
2. Repealer filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

§ 2545.5. Applicability.

HISTORY

1. Amendment of subsection (b)7 filed 6–9–78; effective thirtieth day thereafter (Register 78, No. 23).
2. Repealer filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

Article 12.6. Life Insurance Yield Comparison Index and Net Payment Cost Comparison Index

§ 2546. Authority.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New article 12.6 and section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).

2. Change without regulatory effect repealing article 12.6 (sections 2546–2546.8) and section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.1. Purpose.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.2. Applicability.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Amendment of subsections (b)(6), (b)(11), and (c) filed 9–29–95; operative 10–29–95 (Register 95, No. 39).
3. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.3. Definitions.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Amendment of subsections (q)(1)(A) and (q)(2)–(3) filed 9–29–95; operative 10–29–95 (Register 95, No. 39).
3. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.4. Disclosure Requirements.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Change without regulatory effect amending subsection (c) filed 9–22–94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 38).
3. Amendment of subsection (b) filed 9–29–95; operative 10–29–95 (Register 95, No. 39).
4. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.5. Effective Date.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.6. Buyer's Guide.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Change without regulatory effect designating and amending subsection (a) filed 9–22–94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 38).
3. Amendment filed 9–29–95; operative 10–29–95 (Register 95, No. 39).
4. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.7. Policy Summary.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Amendment of subsection (a)(5)(C) filed 9–29–95; operative 10–29–95 (Register 95, No. 39).
3. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

§ 2546.8. Calculations.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code. Reference: Section 790.02, Insurance Code.

HISTORY

1. New section filed 4–28–94; operative 11–24–94 (Register 94, No. 17).
2. Editorial correction of printing error in subsection (a) (Register 94, No. 23).
3. Change without regulatory effect amending subsection (d) filed 9–22–94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 38).
4. Amendment of subsection (d) and new tables filed 9–29–95; operative 10–29–95 (Register 95, No. 39).
5. Change without regulatory effect repealing section filed 3–24–2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 12).

Article 12.7. Life Insurance Advertisements

§ 2547. Authority.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Section 790.10 of the Insurance Code.

NOTE: Authority cited: Section 790.10, Insurance Code. Reference: Section 790.03, Insurance Code.

HISTORY

1. New Article 12.7 (Sections 2547, 2547.1–2547.11) filed 8–13–75; effective thirtieth day thereafter (Register 75, No. 33).

§ 2547.1. Purpose.

The purpose of these regulations is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

§ 2547.2. Definitions.

For the purpose of these regulations:

(a) "Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides for life insurance or annuity benefits.

(b) "Insurer" shall include any organization or person which issues life insurance or annuities to residents of this state.

(c) "Advertisement" shall be material designed to create public interest in life insurance or annuities or in an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy including:

(1) printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

(2) descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters;

(3) material used for the recruitment, training, and education of an insurer's sales personnel, agents, solicitors and brokers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate or retain a policy;

(4) prepared sales talks, presentations, and material for use by sales personnel, agents, solicitors and brokers.

(d) "Advertisement" for the purpose of these regulations shall not include:

(1) communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(2) communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy;

(3) a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged; provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

§ 2547.3. Applicability.

(a) These regulations shall apply to any life insurance or annuity advertisement intended for dissemination in this State.

(b) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all adver-

tisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer.

§ 2547.4. Form and Content of Advertisements.

(a) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Insurance Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(b) No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

§ 2547.5. Disclosure Requirements.

(a) The information required to be disclosed by these regulations shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(b) No advertisement shall omit material information or use words, phrases, statements, references or illustrations if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(c) In the event an advertisement uses "Non–Medical," "No Medical Examination Required," or similar terms where issue is not guaranteed, such terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto, to the effect that issuance of the policy may depend upon the answers to the health questions.

(d) An advertisement shall not use as the name or title of a life insurance policy or an annuity, any phrase which does not include the words "life insurance" or "annuity" unless accompanied by other language clearly indicating it is life insurance or an annuity.

(e) An advertisement shall prominently describe the type of policy advertised.

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(f) An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no agent or commission involved there will be a cost savings to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the Insurance Commissioner prior to use.

(g) An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

(h) An advertisement for a policy with non–level premiums shall prominently describe the premium changes.

(i) Dividends.

(1) An advertisement shall not utilize or describe dividends in a manner which is misleading or has the capacity or the tendency to mislead.

(2) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends are illustrated, they must be based on the insurer's current dividend scale and the illustrations must contain a statement to the effect that they are not to be construed as guarantees or estimates of dividends to be paid in the future.

(3) An advertisement shall not state or imply that illustrated dividends under a participating policy and/or pure endowments will be or can be sufficient at any future time to assure, without the further payment of premiums, the receipt of benefits, such as a paid–up policy, unless the advertisement clearly and precisely explains (1) what benefits or coverage would be provided at such time and (2) under what conditions this would occur.

(j) An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

(k) Testimonials or Endorsements by Third Parties.

(1) Testimonials used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced. In using a testimonial the insurer makes as its own all of the statements contained therein and such statements are subject to all the provisions of these regulations.

(2) If the individual making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be disclosed in the advertisement.

(3) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the insurer, or receives any payment or other consideration from the insurer for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

(*l*) An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

(m) Introductory, Initial or Special Offers and Enrollment Periods.

(1) An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(2) An advertisement shall not state or imply that only a specific number of policies will be sold or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(3) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised.

(4) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than ten days and not more than forty days from the date of which such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, used by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This rule does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his/her request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this rule shall be applied separately to each such sponsoring organization.

(n) An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group or quasi–group and as such enjoy special rates, dividends or underwriting privileges, unless such is the fact.

(o) An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not falsely or unfairly describe other insurers, their policies, services or methods of marketing.

§ 2547.6. Identity of Insurer.

(a) The name of the insurer shall be clearly identified, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

(b) No advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

§ 2547.7. Jurisdictional Licensing and Status of Insurer.

(a) An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond such limits.

(b) An advertisement may state that an insurer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers may not be so licensed.

(c) An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claims, or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

§ 2547.8. Statements About the Insurer.

An advertisement shall not contain statements, pictures or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

§ 2547.9. Enforcement Procedures.

(a) Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared advertisements of its blanket, franchise and group policies, hereafter disseminated in this State with a notion indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

(b) Each insurer subject to the provisions of these regulations shall file with this Department with its Annual Statement a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by or on behalf of the insurer in this State during the preceding statement year, or during the portion of such year when these regulations were in effect, complied or were made to comply in all respects with the provisions of these regulations and the insurance laws of this State as interpreted by these regulations.

§ 2547.10. Conflict with Other Regulations.

It is not intended that these regulations conflict with or supersede any regulations currently in force or subsequently adopted in this State governing specific aspects of the sale or replacement of life insurance including, but not limited to, rules dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance and replacement of life insurance policies. Consequently, no disclosure required under any such regulations shall be deemed to be an advertisement within the meaning of these regulations.

§ 2547.11. Severability Provision.

If any Section or portion of a Section of these regulations or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulations or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

Article 12.9. Viatical Settlements

§ 2548.1. Authority and Purpose.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner by Sections 10113.1 and 10113.2 of the Insurance Code. The purpose of these regulations is to implement and clarify Sections 10113.1 and 10113.2.

NOTE: Authority cited: Sections 790.10, 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New article 12.9 (sections 2548.1–2548.8) and section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.2. Definitions.

As used in these regulations:

(a) "Catastrophic or life–threatening illness or condition" is an illness or condition that will result in a drastically limited life span not exceeding 24 months. Any of the following are presumed to constitute a catastrophic or life–threatening illness or condition unless a licensed physician or independent medical underwriter states that the insured has a life expectancy exceeding 24 months:

(1) A medical condition that has required or requires extraordinary medical intervention, such as a major organ transplant or continuous artificial life support, without which the insured person would die;

(2) A medical condition that requires continuous daily nursing care or confinement in a nursing home, convalescent enter or other care facility, if the insured person is expected to remain there for the rest of the insured person's life; or

(3) A medical condition that in the absence of extensive or extraordinary medical treatment will result in a drastically limited life span. Such medical conditions include but are not limited to:

(A) Coronary artery disease resulting in an acute infarction or requiring surgery;

(B) Permanent neurological deficit resulting in acute form cerebral vascular accident;

(C) End–stage renal failure; or

(D) Acquired Immune Deficiency Syndrome.

(b) "Entering into" includes, but is not limited to, acquiring an ownership interest in a life insurance policy which is the subject of a viatical settlement, including a collateral interest, through an assignment, purchase, devise, bequest or other transfer, except as provided for in section 2548.2(i)(1) and (2).

(c) "Person" includes any natural person or legal entity including, but not limited to, individuals, partnerships, associations, trusts, or corporations, including a resident or nonresident life and disability agent licensed by the Commissioner.

(d) "Soliciting" includes, but is not limited to, offering or advertising viatical settlements or viatical settlement investments to any person in this state, through any newspaper or other publication, television, radio, the internet, or any other advertising device, or in person.

(e) "Viatical settlement" and "viatical settlement agreement" mean an agreement entered into between a viatical settlement provider and a viator, as such words are defined in sections 2548.2(i) and (j) herein. A viatical settlement includes any sale of a life insurance policy subsequent to the sale from the viator.

(f) "Viatical settlement broker" means any person domiciled, residing or conducting business in California who, for a fee, commission, or other valuable consideration, solicits or offers the availability of viatical settlements, introduces viators to viatical settlement providers, or offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. Regardless of how or by whom a viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and not the insurer or the viatical settlement provider and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interests of the viator. A person acting as a viatical settlement broker must obtain a license from the Commissioner. The requirements of this rule are in addition to any other requirements provided by the Corporate Securities Law of 1968. Viatical settlement broker does not include:

(1) an attorney, an accountant, or financial planner, retained to represent the viator whose compensation is paid solely by the viator and without regard to whether a viatical settlement is effected; or

(2) A person who is employed by a licensed viatical settlement broker, so long as he or she is considered an employee for federal and state tax purposes.

(g) "Viatical settlement investment" is any legal or beneficial interest in a viatical settlement offered to a purchaser other than to a licensed viatical settlement provider. This definition is in addition to any definition or requirement imposed by the Corporate Securities Law of 1968.

(h) "Viatical settlement investment broker" means any person domiciled, residing or conducting business in California who, for a fee, commission, or other valuable consideration, solicits or offers the availability of one or more viatical settlement investments to any person, introduces any person to a viatical settlement provider for the purpose of purchasing one or more viatical settlement investments, or offers to negotiate one or more viatical settlement investments between any person and a viatical settlement provider. A person must obtain a license from the Commissioner to act as a viatical settlement investment broker. The requirements of this rule are in addition to any other requirements provided by the Corporate Securities Law of 1968. A viatical settlement investment broker does not include an attorney, an accountant, or financial planner, retained to represent the investor, whose compensation is paid solely by the investor and without regard to whether a viatical settlement investment is effected.

(i) "Viatical settlement provider" means any person domiciled, residing or conducting business in California who enters into a viatical settlement agreement with a viator. A viatical settlement provider includes any person who has an ownership interest in the insurance policy which is the subject of a viatical settlement, including but not limited to a collateral ownership interest, and including subsequent owners of the life insurance policy which is the subject of a viatical settlement. A viatical settlement provider must obtain a viatical settlement license from the Commissioner. The requirements of this rule are in addition to any other requirements provided by the Corporate Securities Law of 1968. Viatical settlement provider does not include:

(1) a bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan and not as part of any transaction or agreement defined herein as a viatical settlement;

(2) the issuer of a life insurance policy providing accelerated benefits under California law and pursuant to the insurance policy; or

(3) an employee of a licensed viatical settlement provider, so long as he or she is considered an employee for federal and state tax purposes.

(j) "Viator" means a person who is a resident of this state who owns a life insurance policy, or the certificate holder under a group policy, insuring the life of a person with a catastrophic or life threatening illness or condition who enters into, or is considering entering into an agreement under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

NOTE: Authority cited: Sections 790.10, 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.3. Transfers to Unlicensed Persons.

A licensee or applicant shall not directly or indirectly assign, transfer, sell, resell, or transfer by gift or bequest, or otherwise convey any life insurance policy that is or has been the subject of a viatical settlement, to any person that does not hold a California license as a viatical settlement provider issued by the Commissioner and without obtaining the written consent of the viator. The requirements of this rule are in addition to any other requirements provided by the Corporate Securities Law of 1968. Nothing herein shall be construed as preventing the assignment of a beneficial interest in any life insurance policy that is or has been the subject of a viatical settlement.

NOTE: Authority cited: Sections 790.10, 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.4. Designation of Third Party Contacts; Contacts with the Insured.

A person insured under a life insurance policy or certificate of insurance which is the subject of a viatical settlement as defined under these regulations may designate a third party to receive and respond to all inquiries by a viatical settlement provider regarding the health status of that insured person. Contact with the insured person or his or her designee for the purpose of determining the health status of that insured person by viatical settlement provider shall be limited to once every three (3) months if the insured person has a life expectancy of more than one (1) year, and to no more than once per month if the insured person has a life expectancy of one year or less. The viatical settlement provider shall explain, in a written instrument delivered to the insured, the procedure for these contacts prior to the time the viator enters into the corresponding viatical settlement agreement. The limitations set forth in this section shall not apply to any contacts with an insured under a viaticated policy for reasons other than determining the insured's health status.

NOTE: Authority cited: Sections 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.5. Disclosures.

At the time an offer is made to the viator, the viatical settlement provider or the viatical settlement broker shall disclose in writing to the viator:

(a) the affiliation, if any, between the insurer providing coverage under the subject life insurance policy and the viatical settlement broker, and/or viatical settlement provider;

(b) the affiliation, if any, between the viatical settlement provider and the viatical settlement broker;

(c) the amount of commission or other consideration to be paid by the viatical settlement provider to the viatical settlement broker;

(d) the insured's right to designate a third party to receive and respond to all inquiries by the viatical settlement provider regarding the viator's health after the viatical settlement agreement is executed;

(e) the method and the frequency of contact with the insured or a designee of the insured for the purpose of determining the health status of the insured, after the viatical settlement is entered;

(f) all estimates of the life expectancy of the insured which are obtained by a licensee in connection with the viatical settlement, unless such disclosure would violate any California or federal privacy laws;

(g) the following notice, in 12–point bold print: NOTICE: YOU MAY HAVE ALTERNATIVES TO SELLING YOUR LIFE INSURANCE POLICY SUCH AS ACCELERATED BENEFITS, CASHING OUT YOUR POLICY, OR USING YOUR POLICY AS COLLATERAL FOR A LOAN. CONTACT YOUR INSURANCE COMPANY FOR FURTHER INFORMATION AND CAREFULLY REVIEW ALL OF YOUR OPTIONS; and

(h) notice that a policy may be resold only to an entity or person who holds a viatical settlement license from the Commissioner, and only with the written permission of the insured.

If a viatical settlement broker satisfies these disclosure requirements, then a viatical settlement provider shall be deemed to have satisfied this section so long as the viatical settlement provider maintains on file a copy of these written disclosures.

NOTE: Authority cited: Sections 790.10, 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.6. Escrow Account.

Within 15 calendar days of the viatical settlement provider's receipt of documents to effect the transfer of a legal or beneficial interest in the life insurance policy which is the subject of the viatical settlement agreement, the viatical settlement provider shall deposit the proceeds payable to the viator under the viatical settlement into an escrow or trust account

in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the viatical settlement contract. An attorney or law firm representing the viatical settlement provider shall not be the escrow agent for the viatical settlement provider. The trustee or escrow agent shall transfer the proceeds to the viator within 3 business days following the viatical settlement provider's receipt of acknowledgment of the transfer of ownership of or beneficial rights to the insurance policy.

NOTE: Authority cited: Sections 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.7. General Rules.

Viatical settlement licensees shall not:

(a) pay or offer to pay any finder's fee, commission, or other compensation to any person who is required to be a licensee under Section 10113.2 of the Insurance Code, but who is not duly licensed;

(b) enter into any viatical settlement in which payments to the viator are to be made in installments;

(c) engage in any acts determined by the Commissioner to be unfair, deceptive or harassing;

(d) deduct the viatical settlement broker's fee or other valuable consideration from the amount paid or quoted to the viator;

(e) act in the capacity of both a viatical settlement broker and a viatical settlement provider unless authorized in advance and in writing by the Commissioner;

(f) act as a viatical settlement broker after having acted as an insurance agent or broker with respect to the same life insurance policy or certificate of insurance coverage unless written disclosure of this potential conflict of interest is provided by the viatical settlement broker to the viator;

(g) destroy any material records such as purchase agreements, assignments, powers of attorney, escrow agreements, changes of beneficiary, medical records releases, other releases, disclosures, and other material documents, pertaining to a viatical settlement for (5) five years after the date of execution of the viatical settlement;

(h) act as a viatical settlement provider, viatical settlement broker or viatical settlement investment broker with respect to a viatical settlement involving a life insurance policy within its contestable or suicide period;

(i) act in ways contrary to the best interests of the viator, or fail to act according to the viator's instructions, while acting as a viatical settlement broker;

(j) offer to buy a policy for an amount less than the policy's cash surrender value or accelerated benefits value;

(k) use forms that have not been approved in advance by the Commissioner; and

(*l*) sell any ownership interest in a viatical settlement business that holds a California viatical settlement license to any entity or person who does not hold a California viatical settlement license, and without authorization from the Commissioner.

NOTE: Authority cited: Sections 790.10, 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

§ 2548.8. Revocation of License; Denial of Application.

The Commissioner shall have the right to suspend or revoke a license of any viatical settlement provider, viatical settlement broker, or viatical settlement investment broker, or deny a viatical settlement license application if the Commissioner finds that:

(a) the licensee or applicant has knowingly or willingly made any material misrepresentation in the application for a license;

(b) the licensee or applicant has been convicted of a felony or misdemeanor under the laws of the United States or any state therein, or a public offense having as one of its necessary elements a fraudulent act, or an act of dishonesty in acceptance, custody or payment of money or property;

(c) the licensee or applicant has violated any provisions of Title 10 of the California Code of Regulations, or the California Insurance Code, including but not limited to has failed to remit on a timely basis license renewal fees or has failed to file an annual statement;

(d) the licensee or applicant has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with him to the danger of loss;

(e) the licensee no longer meets the qualification for a license to transact viatical settlement business;

(f) the licensee or applicant does business with an unlicensed company or individual where licensing for the capacity in which the company or individual acts is required;

(g) the viatical settlement provider or applicant has failed to honor contractual obligations set out in a viatical settlement contract;

(h) the viatical settlement provider has failed to establish and maintain an escrow account pursuant to Section 2548.6 of these regulations;

(i) the licensee or applicant has been refused a professional, occupational, or vocational license, or had such license suspended or revoked by any licensing authority for the reasons that should preclude the granting of the license applied for;

(j) the licensee or applicant has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner;

(k) the licensee or applicant has knowingly misrepresented the terms or effect of a viatical settlement contract or viatical investment;

(*l*) the licensee or applicant has aided or abetted any person in the act or omission which would constitute grounds for the suspension, revocation or refusal of a license issued under this code to the person aided or abetted;

(m) the licensee or applicant has permitted anyone who is an employee of the licensee or applicant to violate Title 10 of the California Code of Regulations or the California Insurance Code.

NOTE: Authority cited: Sections 790.10, 10113.1 and 10113.2, Insurance Code. Reference: Sections 10113.1 and 10113.2, Insurance Code.

HISTORY

1. New section filed 12–22–2006; operative 1–21–2007 (Register 2006, No. 51).

Article 13. Exemption from Limitations on Cancellation and Nonrenewal of Coverage

§ 2550. Exemptions.

(a) Insurance in respect to any risk or class of risks described in (b) and (c) is exempt from those provisions of Chapter 11, Part 1, Division 1, of the Insurance Code (commencing with Section 675) other than Section 679.6.

(b) The exemption granted in (a) shall apply to insurance (whether on an all–risks basis or a named perils basis) against loss of or damage to personal property under scheduled or blanket personal property floaters whether written separately or as a supplemental contract or endorsement when the aggregate amount of insurance on the schedule or policy exceeds $25,000 or when a single risk exceeds $5,000.

(c) The exemption granted in (a) shall apply to all animal mortality policies.

NOTE: Authority cited: Section 679.6, Insurance Code.

HISTORY

1. New Article 13 (Section 2550) filed 7–19–72; effective thirtieth day thereafter (Register 72, No. 30).

Article 14. Title Insurance

§ 2555. Authority. [Repealed]

NOTE: Authority cited: Section 12389, 12401.5 and 12414.21, Insurance Code.

HISTORY

1. New Article 14 (Sections 2555–2556.2, not consecutive) filed 3–29–74; designated effective 5–1–74 (Register 74, No. 13).

2. Repealer of article 14 and repealer of section filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2555.1. Purpose. [Repealed]

HISTORY

1. Repealer filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2556. Maintenance of Records. [Repealed]

HISTORY

1. Repealer filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2556.1. Filing of Rates and Reporting of Statistics. [Repealed]

HISTORY

1. Repealer filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

§ 2556.2. Rating Examinations. [Repealed]

HISTORY

1. Repealer filed 7–26–2007; operative 11–23–2007 pursuant to Government Code section 11343.4(b) (Register 2007, No. 30).

Article 15. Discrimination on Account of Sex and/or Marital Status

§ 2560. Authority.

This Article is promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Section 790.10 of the Insurance Code.

NOTE: Authority cited: Section 790.10, Insurance Code.

HISTORY

1. New Article 15 (Sections 2560, 2560.1–2560.6) filed 12–2–75; designated effective 1–1–75 (Register 75, No. 49).

§ 2560.1. Purpose.

The purpose of this Article is to eliminate unfair discrimination based upon sex, marital status or sexual orientation in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers.

§ 2560.2. Definition of Contract.

For the purpose of this Article, the term "contract" includes any insurance policy, plan, certificate, subscriber agreement, statement of coverage, binder, rider or endorsement offered by any person or entity engaged in the business of insurance in this State.

§ 2560.3. Prohibited Practices.

No person or entity engaged in the business of insurance in this State shall refuse to issue any contract of insurance or shall cancel or decline to renew such contact because of the sex, marital status or sexual orientation of the insured or prospective insured. The amount of benefits payable, or any term, condition or type of coverage shall not be restricted, modified, excluded or reduced on the basis of the sex, marital status or sexual orientation of the insured or prospective insured. (However, marital status may be considered for the purpose of determining eligibility for dependents' or family coverage.) Examples of the practices prohibited by this section include, but are not limited to:

(a) Denying, cancelling or refusing to renew coverage, or providing coverage on different terms, because the insured or prospective insured is residing with another person or persons not related to him or her by blood or marriage;

(b) Offering coverage to males gainfully employed at home, employed part–time or employed by relatives while denying or offering reduced coverage to females similarly employed;

(c) Reducing disability benefits for females who become disabled while not gainfully employed full–time outside the home when a similar reduction is not applied to males;

(d) Denying females waiver of premium provisions that are available to males or offering such provisions to females only for contract limits that are lower than those available to males;

(e) Refusing to offer maternity benefits to insureds or prospective insureds purchasing individual contracts when comparable family coverage contracts offer maternity benefits;

(f) Denying, under group contracts, dependent's coverage to husbands of female employees when dependent's coverage is available to wives of male employees;

(g) Offering coverage to males in certain occupations while denying coverage or offering more limited coverage to females in the same occupational categories;

(h) Offering males higher benefit levels and/or longer benefit periods than are offered to females in the same classifications;

(i) Offering contracts containing different definitions of disability for females and males in the same classifications;

(j) Offering contracts containing different waiting and elimination periods for females and males;

(k) Requiring female applicants to submit to medical examinations while not requiring males to submit to such examinations for the same coverage;

(*l*) Establishing different benefit options for females and males;

(m) Denying to divorced or single persons coverage available to married persons;

(n) Limiting the amount of coverage available to an insured or prospective insured based upon his or her marital status;

(o) Denying employees of one sex insurance benefits that are offered to dependents who are of the same sex as the employees;

(p) Denying a married or separated female the right to obtain coverage in her own name;

(q) Establishing different issue age requirements for females and males;

(r) Establishing different occupational classifications for females and males;

(s) Denying coverage to unwed mothers and/or their dependents;

(t) Refusing to continue coverage on a spouse or ex–spouse while continuing coverage on the other spouse or ex–spouse following separation or dissolution of a married couple previously covered under a family or household contract.

§ 2560.4. Remedy for Past Discriminations.

Any person who, prior to the effective date of this Article, has been denied insurance coverage on the basis of sex, marital status or sexual orientation may submit to the Commissioner, within one year following the effective date of this Article, a complaint setting forth the details of such denial to the best of such person's knowledge and belief. The Commissioner shall investigate the facts set forth in such complaint and shall take such action as he deems appropriate.

§ 2560.5. Severability Provision.

If any provision of this Article or the application thereof to any person or circumstance is for any reason held invalid, the remainder of this Article and the application of such provision to any other persons or circumstances shall not be affected thereby.

§ 2560.6. Effective Date.

This Article shall be effective on January 1, 1976. Provisions which are contained in group contracts in force on the effective date of this Article and which are not in compliance with this Article may continue in effect until no later than the renewal anniversaries of such contracts next following the effective date of this Article.

Article 16. Home Protection Companies

§ 2570. Authority.

This Article is promulgated pursuant to the authority granted to the Commissioner under the provisions of Part 7, Division 2 of the Insurance Code.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

HISTORY

1. New Article 16 (Sections 2570–2570.09, not consecutive) filed 3–8–79; effective thirtieth day thereafter (Register 79, No. 10).
2. New Article 16 (Sections 2570–2570.09, not consecutive) refiled 3–16–79 as an emergency; effective upon filing (Register 79, No. 10).

§ 2570.01. Purpose.

The purpose of this Article is to implement the provisions of Part 7 (commencing with Section 12740) to Division 2 of the Insurance Code, relating to home protection companies. This law was added to the Insurance Code effective September 26, 1978, as an urgency statute to give the Commissioner regulatory authority over home protection companies conducting a home protection business in this State.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

§ 2570.02. Definitions.

(a) "Unearned home protection contract fees" as used in Section 2570.06(g)(2) (B)7 and the reserves contemplated in Section 985 of the Insurance Code as required by Section 12751 of the Insurance Code means that a home protection company must make provision for reinsurance of the outstanding risk on policies which provide that premiums are fully earned at inception and on policies which for any other reason do not provide for a return premium to the insured on cancellation prior to expiration.

Standards for reasonably estimating the amount required to reinsure under Sections 980 through 988 of the Insurance Code to provide adequate safeguards for the contract holders, creditors and the public will be provided from time to time by the Commissioner after giving consideration to the developing experience of the home protection business.

(b) "Service claims adjusted and unpaid or in the process of adjustment" as used in Section 2570.06(g)(2) (B)1 means a reserve estimated in the aggregate to provide for the payment of all service claims for which a home protection company may be liable and to provide for the expense of adjustment or settlement of all service claims. This includes the cost to purchase home appliances, systems or components and to pay for installation and service.

"Service claim" as used herein means a claim by the holder of a home protection contract for the provision of service for the replacement or repair of a covered appliance, system or component pursuant to a home protection contract.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

§ 2570.03. Home Protection Company License Requirement.

No person shall issue or offer to issue home protection contracts in this state unless such person (1) holds a valid home protection company license issued by the Commissioner, or (2) holds a valid Certificate of Authority to transact miscellaneous insurance under Insurance Code Section 120.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

§ 2570.04. Application Procedure for Home Protection Companies.

(a) A domestic home protection company incorporated and capitalized prior to January 1, 1979 or a foreign home protection company incorpo-

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rated, capitalized and conducting a home protection company business in California prior to January 1, 1979 shall file with the Commissioner an application on the form furnished by the Commissioner and submit the exhibits specified in Section 2570.06 on or before March 31, 1979.

(b) A domestic home protection company not incorporated and capitalized prior to January 1, 1979 shall comply with the following procedures prior to the commencement of business:

(1) Apply for a corporate name approval from the Commissioner pursuant to Insurance Code Section 880 et seq.;

(2) Incorporate under the California General Corporations Law;

(3) File an application for a security permit with the Commissioner pursuant to Section 2570.08;

(4) Capitalize in accordance with the terms and conditions of the security permit issued;

(5) Correct any deficiencies found during field examination conducted by the Commissioner; and

(6) File an application on a form furnished by the Commissioner for a license pursuant to Section 2570.06 and obtain a license from the Commissioner to conduct a home protection company business.

(c) A foreign home protection company not conducting a home protection company business in California prior to January 1, 1979 shall file with the Commissioner an application on the form furnished by the Commissioner and submit the exhibits specified in Section 2570.06.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

§ 2570.06. Exhibits to Be Submitted by Applicant.

An applicant for a license to conduct a home protection company business shall submit the following exhibits with its application.

(a) Fees.

(1) Application fee.

(2) Name(s) of marketing representatives (Make check payable to the California Department of Insurance.)

(b) Taxes.

Executed tax bond or security deposit.

(c) Name Approval.

(1) Request for corporate name approval letter.

(2) Request for marketing representatives name(s) approval letter.

(d) Authorization for Disclosure of Financial Records.

Executive disclosure of financial records authorization.

(e) Organization.

(1) Articles of incorporation and all amendments certified by the secretary of state.

(2) By–laws certified by the corporate secretary.

(3) Minutes of initial meeting of the incorporators or board of directors certified by the corporate secretary if the applicant is being organized on or after January 1, 1979.

(4) Completed registration statement Form "B," if your company is a member of a holding company system.

(5) Functional staffing organization chart showing the name and title of all directors, officers and key managerial personnel.

(6) Biographical affidavit on a form furnished by the Commissioner for each person controlling 10% or more of applicant's stock directly or indirectly and each person named on the applicant's functional staffing organization chart who does not have a recent biographical affidavit on file with the Commissioner.

(7) The name of each director of the applicant who is a director of any insurer or other home protection company together with the name of all such insurers or other home protection companies.

(8) Procedures of the applicant to determine the existence of possible conflicts of interest with directors, officers or key managerial personnel.

(9) Copy of any current or proposed outside management, consulting, employment or administration agreement certified by the corporate secretary.

(10) Certificate of good standing from the home state.

(f) Plan of Operation.

(1) The plan of operation exhibit may be submitted in a narrative form and should include information with regard to the following:

(A) Products. Briefly explain the applicant's home protection contract in regard to coverage, exclusions, terms, average price and other relevant items.

(B) Marketing. Describe the manner in which these products will be marketed. Submit copies of applicant's marketing material such as pamphlets, brochures, handbooks and advertising.

(C) Underwriting and Rating. Describe the applicant's underwriting and rating practices and procedures. Include a copy of the following:

1. All contracts, applications, endorsements, amendments or rider forms intended for use in California.

2. Underwriting manual or underwriting guidelines intended for use in California.

3. Rate charts intended for use in California.

4. Copy of any actuarial study, market research study, or summary of experience upon which applicant's proposed rates are based.

5. Copy of applicant's rating manual or a description of applicant's rate making methodology.

(D) Provision of Service. Briefly explain how and by whom service claims will be processed and service performed. Indicate whether applicant's service providers will be employees or independent contractors and explain how service providers will be compensated. Describe the extent of authority delegated to independent service providers and explain what check is made on the quality of service rendered. Include a copy of the applicant's service manual and service agreements.

(g) Financial Reporting Requirements.

(l) A copy of applicant's most recent audited financial statement prepared by an independent certified public accountant or independent licensed public account. If applicant's financial statement was not audited, it must be verified by the applicant's president and secretary.

(2) A financial statement prepared in accordance with statutory requirements as of the date of application showing:

(A) Assets.

1. Bonds.*
2. Stocks.*
a. preferred stocks.
b. common stocks.
3. Mortgage loans on real estate.
a. first liens.
b. other than first liens.
4. Real estate,* less encumbrances.
5. Collateral loans.
6. Cash on hand and on deposit.
a. cash in company's office.
b. cash on deposit.
7. Other invested assets.
8. Protection contract fees receivable.**
9. Service fees receivable.***
10. Federal income tax recoverable.
11. Electronic data processing equipment.
12. Interest, dividends and real estate income due and accrued.
13. Prepaid claim expense.****
14. Total assets.

(B) Liabilities, Surplus and Other Funds.

1. Service claims adjusted and unpaid or in process of adjustment.
2. Other expenses (excluding taxes, licenses and fees).
3. Taxes, licenses and fees (excluding federal and foreign income taxes).
4. Federal and foreign income taxes (excluding deferred taxes).
5. Borrowed money.
6. Interest payable.
7. Unearned home protection contract fees.
8. Dividends declared and unpaid to stockholders.

9. All other liabilities.
10. Total liabilities.
11. Capital paid–up.
12. Gross paid–in and contributed surplus.
13. Unassigned funds (surplus).
14. Less treasury stock, at cost.
15. Surplus as regards contract holders.
16. Totals.

(C) Summary of business in force.

Provide the following information:

	California	Other States	Total
Date that home protection company business in California commenced.			
Number of contracts issued or renewed during the preceding calendar year			
Number of contracts in force			
Number of months of liability under unexpired contracts.			
Average price per contract			
Average amount expended per contract for direct provision of service.			
Average amount per contract expended for acquisition and administration expenses			
(3) Audited or verified financial statement for 1977 and 1978 for those companies conducting a home protection company business in California prior to January 1, 1979.....			
(4) Copy of any actuarial study or market research report upon which the applicant's financial projection was based ...			
(5) Copy of any contract by which business is shared or pooled with another home protection company or insurer ...			
(6) Salaries and compensation paid or payable to directors, officers and key managerial personnel			
(7) Estimate of all organizational expenses incurred or to be incurred, from initial promotion to issuance of a home protection company license for a company organized on or after January 1, 1979.			

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

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* State basis of valuation.

** Home protection contract fees receivable are allowed as assets to the extent that such fees are actually received subsequent to the end of the statement period on contracts which became effective prior to the end of the statement period.

*** Service fees receivable are allowable as an asset to the extent that such fees are actually received within 15 days following the end of the statement period.

**** Furniture, fixtures, office equipment and supplies, leasehold improvements, organization expenses, intangible assets, deferred charges and prepaid expenses are not allowable assets except that prepaid claims expense consisting of automobiles, trucks and appliances used solely and directly in servicing claims may be taken as an asset at depreciated cost.

§ 2570.07. Additional Requirements for Foreign Applicants.

A foreign applicant shall also file the following exhibits.

(a) Notice of appointment of agent for service of process.

(b) Latest annual and quarterly statements to date certified by applicant's home state regulatory official to be true and correct copies.

(c) Latest examination report certified by applicant's home estate regulatory official to be a true and correct copy.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

§ 2570.08. Exhibits to Be Submitted in Support of a Security Permit Application.

A home protection company applying for a security permit shall submit the following:

(a) Security permit application fee.

(b) A voided specimen of any share certificate or other security which applicant proposes to issue.

(c) If the sale is by subscription, a list of all proposed share purchasers, the amount of shares to be purchased by each subscriber, the aggregate consideration to be paid by each subscriber and identification of the promoters by means of an asterisk.

(d) Prospectus or offering circular, or a statement why it should not be required. No prospectus or offering circular is required if the entire issue will be made to three or less subscribers, all of whom are promoters.

(e) Copy of any letter to stockholders, offering letter or other solicitation material.

(f) Stock subscription agreement.

(g) Agreement restricting transfer of shares.

(h) Impound agent instructions and letters of consent to act as escrow agent.

(i) Underwriter's agreement concerning the issue or providing for sale or disposition of applicant's shares.

(j) Names of all persons who will solicit the sale of these securities and their addresses, relationships to the applicant, production and securities licenses held and compensation for the sale of these securities, if any.

(k) The plan of operation as specified in Section 2570.06 (f).

(*l*) A two–year financial projection.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

§ 2570.09. Filing Instructions.

(a) All applications for a home protection company license shall be filed with the Corporate Affairs Bureau, Legal Division, San Francisco Office.

(b) Submit an original and one copy of the application, index of exhibits and all exhibits.

(c) The applications and exhibits must comply with the following requirements:

(1) The documents should be arranged as follows:

Application
Index of Exhibits
Exhibits (lower right hand side of the exhibits should indicate the number or description corresponding to the index).

(2) In the event that an exhibit is not submitted with the application, please so indicate.

(3) Supplements or amendments to exhibits should be submitted and marked in the same manner as original exhibits. Each supplement or amendment should consist of a whole document or complete pages of a document paginated to correspond to existing exhibits so that the new material can be readily inserted into the existing file.

(4) Every application will be assigned a file number. Applicants will be notified on the file number and filing date, and all subsequent correspondence shall bear the file number.

(5) The application, amendments and supplements shall be verified as required by the Code of Civil Procedures Sections 446 and 2015.5.

NOTE: Authority cited: Section 2570, California Insurance Code. Reference: Sections 771.1, 831.1, 881.1, 882.5, 988, 1215.13 1/2, 1634, 1635, Part 7 commencing with Section 12740 of Division 2, Insurance Code.

Article 17. Actuarial Opinion and Memorandum Regulation

§ 2580.1. Purpose.

The purpose of this regulation is to prescribe:

(a) Requirements for statements of actuarial opinion that are to be submitted in accordance with Section 10489.15 of the Insurance Code, and for memoranda in support thereof;

(b) Rules applicable to the appointment of an appointed actuary; and

(c) Guidance as to the meaning of "adequacy of reserves."

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New article and section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Amendment filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.2. Scope.

This regulation shall apply to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies that are authorized to reinsure life insurance, annuities or accident and health insurance business in this State. This regulation shall be applied in a manner that allows the Appointed Actuary to utilize his or her professional judgment in performing the Asset Adequacy Analysis and developing the Actuarial Opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the Commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the Commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relating to the adequacy of reserves and related items.

This regulation shall be applicable to all annual statements filed with the office of the Commissioner after the effective date of this regulation. A statement of opinion on the adequacy of the reserves and related actuarial items based on an Asset Adequacy Analysis in accordance with Section 2580.5 of this regulation, and a memorandum in support thereof in accordance with Section 2580.6 of this regulation, shall be required each year.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Amendment filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.3. Definitions.

(a) "Actuarial Opinion" means the opinion of an Appointed Actuary regarding the adequacy of the reserves and related actuarial items based on an Asset Adequacy Analysis test in accordance with Section 2580.5 of this regulation and with applicable Actuarial Standards of Practice.

(b) "Actuarial Standards Board" is the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(c) "Annual Statement" means that statement required by Section 900 of the Insurance Code to be filed by the Company with the office of the Commissioner annually.

(d) "Appointed Actuary" means any individual who is appointed or retained in accordance with the requirements set forth in Subsection 2580.4(c) of this regulation to provide the Actuarial Opinion and supporting memorandum as required by Section 10489.15 of the Insurance Code.

(e) "Asset Adequacy Analysis" means an analysis that meets the standards and other requirements referred to in Subsection 2580.4(d) of this regulation.

(f) "Commissioner" means the Insurance Commissioner of the State of California.

(g) "Company" means a life insurance company, fraternal benefit society or reinsurer subject to the provisions of this regulation.

(h) "Qualified Actuary" means any individual who meets the requirements set forth in Subsection 2580.4(b) of this regulation.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Amendment filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.4. General Requirements.

(a) Submission of Statement of Actuarial Opinion.

(1) There is to be included on or attached to Page 1 of the Annual Statement for each year beginning with the year in which this regulation becomes effective the statement of an Appointed Actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Section 2580.5 of this regulation.

(2) Upon written request by the Company, the Commissioner may grant an extension of the date for submission of the Statement of Actuarial Opinion.

(b) A "qualified actuary" is an individual who:

(1) Is a member in good standing of the American Academy of Actuaries; and

(2) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements;

(3) Is familiar with the valuation requirements applicable to life and health insurance companies;

(4) Has not been found by the Commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have:

(A) Violated any provision of, or any obligation imposed by, the Insurance Law or other law in the course of his or her dealings as a qualified actuary;

(B) Been found guilty of fraudulent or dishonest practices;

(C) Demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(D) Submitted to the Commissioner during the past five years, pursuant to this regulation, an actuarial opinion or memorandum that the Commissioner rejected because it did not meet the provisions of this regulation including standards set by the Actuarial Standards Board; or

(E) Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(5) Has not failed to notify the Commissioner of any action taken by any Commissioner of any other state similar to that under Paragraph (4) above.

(c) An "appointed actuary" is a Qualified Actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this regulation, either directly by or by the authority of the board of directors through an executive officer of the Company who is not said Qualified Actuary. The Company shall mail the Commissioner timely notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the Company as an appointed actuary and shall state in the notice that such person meets the requirements set forth in Subsection 2580.4(b). Once notice is furnished, no further notice is required with respect to this person, provided that the Company shall inform the Commissioner by written notice postmarked or received within sixty calendar days of the event, in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirement set forth in Subsection 2580.4(b). If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

(d) Standards for Asset Adequacy Analysis.

The asset adequacy analysis required by this regulation:

(1) Shall conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and any additional standards under this regulation, which standards are to form the basis of the statement of Actuarial Opinion in accordance with this regulation; and

(2) Shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

(e) Liabilities to be Covered.

(1) Under the authority of Section 10489.15 of the Insurance Code, the statement of Actuarial Opinion shall apply to all in force business on the statement date, whether directly issued or assumed, regardless of when or where issued, namely, reserves of Exhibits 5, 6, and 7, and claim liabilities in Exhibit 8, Part 1 and any other policy or contract liabilities and equivalent items in the separate account statement or statements. Exhibits 5, 6, 7, and 8 are included in the chart attached to Paragraph 2580.5(b)(2).

(2) If the Appointed Actuary determines as the result of Asset Adequacy Analysis that a reserve should be held in addition to the aggregate reserve held by the Company and calculated in accordance with methods set forth in Division 2, Part 2, Chapter 5, Article 3A (Section 10489.1, et seq.) of the Insurance Code, the Company shall establish the additional reserve.

(3) Additional reserves established under Paragraph (2) above and deemed not necessary in subsequent years may be released. Any amounts released must be disclosed in the Actuarial Opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Amendment filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.5. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis.

(a) General Description.

The statement of Actuarial Opinion submitted in accordance with this section shall consist of:

(1) A paragraph identifying the Appointed Actuary and his or her qualifications (see Paragraph 2580.5(b)(1));

(2) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the Appointed Actuary's work, including a tabulation delineating the reserves and related actuarial items that have been analyzed for asset adequacy and the method of analysis, (see Paragraph 2580.5(b)(2)) and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) A reliance paragraph describing those areas, if any, where the Appointed Actuary has deferred to other experts in developing data, procedures or assumptions, (e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see Paragraph 2580.5(b)(3)), supported by a statement of each such expert in the form prescribed by Subsection 2580.5(e); and

(4) An opinion paragraph expressing the Appointed Actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Paragraph 2580.5(b)(6)).

(5) One or more additional paragraphs will be needed in individual Company cases as follows:

(A) If the Appointed Actuary considers it necessary to state a qualification of his or her opinion.

(B) If the Appointed Actuary must disclose an inconsistency in the method of analysis or basis or asset allocation used at the prior opinion date with that used for this opinion.

(C) If the Appointed Actuary must disclose whether additional reserves as of the prior opinion date are released as of this opinion date, and the extent of the release.

(D) If the Appointed Actuary chooses to add a paragraph briefly describing the assumptions which form the basis for the Actuarial Opinion.

(b) Recommended Language.

The following paragraphs are to be included in the statement of Actuarial Opinion in accordance with this section. Language is that which in typical circumstances should be included in a statement of Actuarial Opinion. The language may be modified as needed to meet the circumstances of a particular case, but the Appointed Actuary should use language that clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section.

(1) The opening paragraph should generally indicate the Appointed Actuary's relationship to the Company and his or her qualifications to sign the opinion. For a Company actuary, the opening paragraph of the Actuarial Opinion should include a statement such as:

"I, [name of actuary], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of said insurer to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

For a consulting actuary, the opening paragraph should include a statement such as:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the Annual Statement of the Company, as prepared for filing with state regulatory officials, as of December 31, 20[ ]. Tabulated below are those reserves and related items which have been subjected to Asset Adequacy Analysis.

				Reserves and Liabilities	
Statement Item	*Asset Adequacy Formula Reserves* (1)	*Tested Amounts Additional Actuarial Reserves (a)* (2)	*Analysis Method (b)* (3)	*Other Amount* (4)	*Total Amount (1)+ (2) + (4)* (5)
Exhibit 5					
Life Insurance					
Annuities					
Supplementary Contracts Involving Life Contingencies					
Accidental Death Benefit					
Disability – Active					
Disability – Disabled					
Miscellaneous					
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6					
Active Life Reserve					
Claim Reserve					
Total (Exhibit 6 Item 1, Page 3)					
Exhibit 7					
Premiums and Other Deposit Funds (Column 5, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Other (Column 6, Line 14)					
Supplemental Contracts and Annuities Certain (Column 3, Line 14)					
Dividends and Accumulations or Refunds (Column 4, Line 14)					
Total Exhibit 7 (Column 1, Line 14)					
Exhibit 8 Part 1					
Life (Page 3, Line 4.1)					
Health (Page 3, Line 4.2)					
Total Exhibit 11, Part 1					
Other (Specify)					
Separate Accounts					
(Page 3 of the Annual Statement of the Separate Accounts, Lines 1 and 2, Column 3)					
TOTAL RESERVES					

Statement Item	Asset Adequacy Formula Reserves (1)	Tested Amounts Additional Actuarial Reserves (a) (2)	Analysis Method (b) (3)	Other Amount (4)	Reserves and Liabilities Total Amount (1)+ (2) + (4) (5)
IMR (General Account, Page ___ Line ___)					
(Separate Accounts, Page ___ Line ___)					(c)
AVR (Page ___ Line ___)					
Net Deferred and Uncollected Premium					

Notes:

(a) The additional actuarial reserves are the reserves established under Section 2580.4(e)

(b) The Appointed Actuary should indicate the method of analysis, determined in accordance with the standards for asset analysis referred to in Section 2580.4(d) of this regulation, by means of symbols that should be defined in a footnote to the table.

(c) Allocated amount of Asset Valuation Reserve (AVR).

(3) If the Appointed Actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as:

"I have relied on [name], [title] for [e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios," or "certain critical aspects of the analysis performed in conjunction with forming my opinion"], as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts should be accompanied by a statement by each of such experts in the form prescribed by Subsection 2580.5(e).

(4) If the Appointed Actuary has examined the underlying asset and liability records, the reliance paragraph should also include the following:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

(5) If the Appointed Actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force and/or asset records) prepared by the Company, the reliance paragraph should include a statement such as:

"In forming my opinion on [specifying types of reserves] I relied upon data prepared by [name and title of company officer certifying in force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects, my examination included review of the actuarial assumptions and actuarial methods used, and included such tests of the calculations as I considered necessary."

The section must be accompanied by a statement by each person relied upon in the form prescribed by Subsection 2580.5(e).

(6) The opinion paragraph should include the following:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

(A) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;

(B) Are based on actuarial assumptions that produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;

(C) Meet the requirements of the Insurance Law and regulation of the state of [state of domicile] and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;

(D) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Statement of the preceding year–end (with any exceptions noted below); and

(E) Include provision for all actuarial reserves and related statement items which ought to be established.

1. The reserves and related items, when considered in light of the assets held by the Company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company. (At the discretion of the Commissioner, the preceding sentence may be omitted for an opinion filed on behalf of a domestic Company doing business only in this state and in no other state.)

2. The actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

3.(i) This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.

OR

(ii) The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

NOTE: Choose Subitem (i) or Subitem (ii) above, whichever is applicable.

4. The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

_____

Signature of Appointed Actuary

_____

Address of Appointed Actuary

_____

Telephone Number of Appointed Actuary

E-mail Address of Appointed Actuary

Date"

(c) Assumptions for New Issues.

The adoption for new issues or new claims or other new liabilities of an actuarial assumption that differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this Section 2580.5.

(d) Adverse Opinions.

If the Appointed Actuary is unable to form an opinion, then he or she shall refuse to issue a statement of Actuarial Opinion. If the Appointed Actuary's opinion is adverse or qualified, then he or she shall issue an adverse or qualified Actuarial Opinion explicitly stating the reason(s) for the opinion.

This statement should follow the scope paragraph and precede the opinion paragraph.

(e) Reliance on Information Furnished by Other Persons.

If the Appointed Actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the Actuarial Opinion, or the appropriateness of any other information used by the Appointed Actuary in forming the Actuarial Opinion, the Actuarial Opinion should so indicate the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the Appointed Actuary relies shall provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness, as applicable, of the items. This certification shall include the signature, title, company, address, e-mail address and telephone number of the person rendering the certification, as well as the date on which it is signed.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12-6-94; operative 1-5-95 (Register 94, No. 49).
2. Repealer of former section 2580.5 and renumbering and amendment of former section 2580.7 to section 2580.5 filed 12-27-2004; operative 1-1-2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.6. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary.

(a) General

(1) In accordance with Section 10489.15 of the Insurance Code, the Appointed Actuary shall prepare a memorandum to the Company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the Commissioner upon his or her request but shall be returned to the Company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the Commissioner.

(2) In preparing the memorandum, the Appointed Actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Section 2580.4(b) of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the Commissioner requests a memorandum and no such memorandum is received within 60 calendar days of the date of mailing the request, or if the Commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the Commissioner may designate a Qualified Actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of such independent review shall be paid by the Company but shall be directed and controlled by the Commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the Company and the work papers and documentation of such reviewing actuary shall be retained by the Commissioner; provided, however, that any information provided by the Company to such reviewing actuary and included in the work papers shall be considered as material provided by the Company to the Commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the Company to the Commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three years.

(5) In accordance with Section 10489.15 of the Insurance Code, the Appointed Actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection 2580.6(c). The regulatory asset adequacy issues summary will be submitted no later than March 15 of the year following the year for which a statement of Actuarial Opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(b) Details of the Memorandum Section Documenting Asset Adequacy Analysis.

When an Actuarial Opinion under Section 2580.5 is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for Asset Adequacy Analysis referred to in Subsection 2580.4(d) of this regulation and any additional standards under this regulation. It shall specify:

(1) For reserves:

(A) Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the Appointed Actuary deems significant;

(B) Source of liability in force;

(C) Reserve method and basis;

(D) Investment reserves;

(E) Reinsurance arrangements;

(F) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the Appointed Actuary to provide for the guarantees in the Asset Adequacy Analysis; and

(G) Documentation of assumptions to test reserves for the following:

1. Lapse rates (both base and excess);
2. Interest crediting rate strategy;
3. Mortality;
4. Policyholder dividend strategy;
5. Competitor or market interest rate;
6. Annuitization rates;
7. Commissions and expenses; and
8. Morbidity.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(2) For assets:

(A) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;

(B) Investment and disinvestment assumptions;

(C) Source of asset data;

(D) Asset valuation bases; and

(E) Documentation of assumptions made for:

1. Default costs;
2. Bond call function;
3. Mortgage prepayment function;

4. Determining market value for assets sold due to disinvestment strategy; and

5. Determining yield on assets acquired through the investment strategy.

The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.

(3) For the analysis basis:

(A) Methodology;

(B) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(C) Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

(D) Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant Actuarial Standards of Practice); and

(E) Whether the impact of federal income taxes was considered and the method of treating reinsurance in the Asset Adequacy Analysis;

(4) Summary of material changes in methods, procedures, or assumptions from prior year's Asset Adequacy Analysis;

(5) Summary of results; and

(6) Conclusions.

(c) Details of the Regulatory Asset Adequacy Issues Summary.

(1) The regulatory asset adequacy issues summary shall include:

(A) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If aggregate negative ending surplus results under certain tests, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount reflecting an appropriate estimate of the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(B) The extent to which the Appointed Actuary uses assumptions in the Asset Adequacy Analysis that are materially different from the assumptions used in the previous Asset Adequacy Analysis;

(C) The amount of reserves and the identity of the product lines that had been subjected to Asset Adequacy Analysis in the prior opinion but were not subject to analysis for the current opinion;

(D) Comments on any interim results that may be of significant concern to the Appointed Actuary;

(E) The methods used by the actuary to recognize the impact of reinsurance on the Company's cash flows, including both assets and liabilities, under each of the scenarios tested;

(F) Whether the actuary has been satisfied that all options, whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity–like features in any investments have been appropriately considered in the Asset Adequacy Analysis; and

(G) Any other items that the Commissioner may request.

(2) The regulatory asset adequacy issues summary shall contain the name of the Company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the Appointed Actuary rendering the Actuarial Opinion.

(d) Conformity to Standards of Practice.

The memorandum shall include a statement:

"Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

(e) Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve.

An appropriate allocation of assets in the amount of the Interest Maintenance Reserve (IMR), whether positive or negative, must be used in any Asset Adequacy Analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the Asset Valuation Reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

The amount of the assets used for the AVR must be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum.

(f) Documentation.

The Appointed Actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Repealer of former section 2580.6 and renumbering of former section 2580.8 and portions of former section 2580.9 to section 2580.6, including amendment of section heading and section, filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.7. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Renumbering of former section 2580.7 to section 2580.5 filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.8. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Renumbering of former section 2580.8 to section 2580.6 filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

§ 2580.9. Additional Considerations for Analysis.

NOTE: Authority cited: Section 10489.15, Insurance Code. Reference: Section 10489.15, Insurance Code.

HISTORY

1. New section filed 12–6–94; operative 1–5–95 (Register 94, No. 49).
2. Repealer of section, including renumbering of portions of former section 2580.9 to section 2580.6, filed 12–27–2004; operative 1–1–2005 pursuant to Government Code section 11343.4 (Register 2004, No. 53).

Article 17.2. Actuarial Confidentiality and Conflict of Interest Regulation

§ 2581.1. Purpose.

These regulations are mandated by Section 10236.12 of the California Insurance Code. The purpose of these regulations is to ensure that independent actuaries, who are retained by the California Department of Insurance to examine long–term care insurance rate filings, maintain the confidentiality of long–term care insurance rate filings and proprietary insurer information, and avoid actual or potential conflicts of interest.

HISTORY

1. New article 17.2 (sections 2581.1–2581.4) and section filed 2–26–2002; operative 3–28–2002 (Register 2002, No. 9).

§ 2581.2. Maintenance of Confidentiality.

Before retaining an independent actuary for examination of long–term care insurance rates, the Commissioner shall require a written declaration by the actuary that:

1. the actuary shall not disclose to another party, other than the California Department of Insurance, and shall protect from unauthorized use, any confidential information obtained in the course of examining long–term care insurance rate filings, unless authorized to do so by the company or required by law; and

2. the actuary shall not disclose to another party and shall protect from unauthorized use, all confidential information obtained from the California Department of Insurance in the course of examining long–term care insurance rate filings.

With respect to this Section, "confidential information" means information not in the public domain, including information of a proprietary nature and information that is legally restricted from circulation.

HISTORY

1. New section filed 2–26–2002; operative 3–28–2002 (Register 2002, No. 9).

§ 2581.3. Avoidance of Conflict of Interest.

Before retaining an independent actuary for examination of long–term care insurance rate filings, the California Department of Insurance shall require a written declaration by the actuary that:

1. the actuary will not perform professional services involving an actual or potential conflict of interest unless:

(a) the actuary's ability to act fairly is unimpaired;

(b) there has been disclosure of the conflict to all present, or known prospective, clients or employers of the actuary's services whose interests would be affected by the conflict; and

(c) all such present, or known prospective, clients or employers of the actuary's services have expressly agreed to the performance of the services by the actuary.

2. The actuary or actuarial firm with which the actuary is affiliated was not involved in establishing the long–term care insurance rates under consideration by the actuary.

3. The actuary has disclosed any financial interest in the company filing the long–term care insurance rates.

HISTORY

1. New section filed 2–26–2002; operative 3–28–2002 (Register 2002, No. 9).

§ 2581.4. Billing of Actuarial Services.

The costs and expenses of all examinations by independent actuaries of such long–term care insurance rate filings shall be paid in accordance with California Insurance Code Sections 733(g) and 736.

NOTE: Authority cited: Section 10236.12, Insurance Code.

HISTORY

1. New section filed 2–26–2002; operative 3–28–2002 (Register 2002, No. 9).

Article 18. The California FAIR Plan Association

§ 2590. Definitions.

As used in this Article:

(a) "The Association" is as defined in California Insurance Code Section 10091(a).

(b) "Basic Property Insurance" is as defined in California Insurance Code Section 10091(c).

(c) "Brush Hazard Areas" are those areas designated by the Insurance Services Office "(ISO") or its successor entity as brush hazard areas subject to catastrophic brush fires.

(d) "Inner City Areas" are those specific areas, which the Commissioner designates within the geographic or urban areas under Insurance Code Section 10091(c) that are underserved by the member insurers, except that Brush Hazard Areas are not Inner City Areas.

(e) "Method" refers to the method for proportionately relieving insurers from participation in the Association pursuant to Insurance Code Section 10094.2 and this article. A method is proportionate if the more an insurer has qualifying premiums the greater that insurer's relief from participation in the Association. Nothing in the Method shall preclude an insurer who qualifies from being wholly relieved of its participation in the Association.

(f) "Qualifying Premiums" are those premiums that a participating insurer derives from risks insured in brush hazard or inner city areas as defined under Sections 2590(c) and (d) above.

NOTE: Authority cited: Section 10094.2, Insurance Code. Reference: Sections 10090, 10091 and 10094.2, Insurance Code.

HISTORY

1. New article 18 (sections 2590–2590.1) and section filed 11–24–99; operative 12–24–99 (Register 99, No. 48).

§ 2590.1. Adoption of Method for Calculating Insurer Credits for Relief from Participation in the Association.

(a) The Association shall adopt and implement a fair and reasonable Method, consistent with Insurance Code Section 10094.2 and this article, that allows eligible insurers whole or partial relief from participation in the Association. Under the Method, an insurer shall be eligible for relief in proportion to the insurer's total premium writings in the following categories, but credit for premium writings in these categories need not be equally weighted:

(1) Basic Property Insurance on risks located in Brush Hazard Areas;

(2) Basic Property Insurance on risks located in Inner City Areas; and

(3) Business owners package insurance on risks located in Inner City Areas.

(b) The Method shall require insurers to apply for any credits granted under Insurance Code Section 10094.2 or this article. The Method shall require applicant insurers to report their voluntary premium writings in each of the categories specified in sub–paragraph (a) to the Association separately in an annual report by a specified date and shall establish binding rules regarding the treatment of late reports.

(c) The Association shall submit a proposed Method to the Commissioner within 90 days of the effective date of this regulation. The Association may submit proposed changes to the Method to the Commissioner at any time. The Method, as well as any proposed changes, must be approved by the Commissioner. Concurrent with any submission, under this subsection, the Association shall notify its member companies of the submission and make the text of the submission available to them.

(d) Within 30 days after the Commissioner notifies the Association that he or she has approved the Method or that he or she requires any change to the Method, the Association shall notify all participating insurers of the approval or change by mail. The Method and changes shall become effective 30 days after the Association mails notification to all participating insurers or on a date specified by the Commissioner, whichever is later. The Commissioner may relieve the Association of the requirement of notifying insurers of any change to the Method if the Commissioner views the change as non–substantive or de minimus. If the Commissioner relieves the Association of the requirement of notifying insurers of a change to the Method, the change shall become effective 30 days after the Commissioner notifies the Association of approval of the change.

(e) If the Association fails to submit a Method to the Commissioner as required by this article, the Commissioner may promulgate another method as he or she may deem necessary to carry out the purpose of Section 10094.2.

(f) If the Commissioner disapproves, withdraws or revokes his or her approval of the Method, the Association shall, within 90 days from the date of the disapproval, withdrawal or revocation, submit to the Commissioner for review an appropriately revised proposed Method, and if the Association fails to do so, the Commissioner may promulgate another

method as he or she may deem necessary to carry out the purpose of Insurance Code Section 10094.2.

NOTE: Authority cited: Section 10094.2, Insurance Code. Reference: Sections 10090, 10091, 10094.2 and 10095, Insurance Code.

HISTORY

1. New section filed 11-24-99; operative 12-24-99 (Register 99, No. 48).

Article 19. Regulations for Enforcement Actions and Penalties

§ 2591. Preamble.

(a) The purpose of this article is to meet the requirements of Insurance Code section 12921.1, paragraph (a)(7). This statute pertains to violations of statutes or regulations which are discovered in the investigation of consumer complaints and requires that the commissioner establish a list of criteria to determine which violations by insurers should be pursued through enforcement action and to establish enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

(b) Pursuant to the commissioner's authority to enforce the Insurance Code, this article shall also apply to actions arising from findings generated by other regulatory activities that allege violations of statutes or regulations. These activities include but are not limited to market conduct examinations or other Department investigations, examinations, or reviews of insurer conduct. This article is intended to provide greater uniformity in enforcement and in the general assessment of penalties imposed upon insurers.

NOTE: Authority cited: Sections 790.10 and 12921.1, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal.3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 704.7, 769.86, 789.3, 790.035, 790.036, 790.07, 790.10, 1858.07, 1858.1, 1858.3, 1859.1, 1861.14, 10140.1, 10140.5, 10149.1, 10199.7, 10234.3, 10509.9, 11756, 12414.25 and 12921.1, Insurance Code.

HISTORY

1. New article 19 (sections 2591–2591.4) and section filed 12–15–2003; operative 1–14–2004 (Register 2003, No. 51).

§ 2591.1. Scope and Purpose.

(a) This article applies to those provisions of the California Insurance Code that allow the commissioner discretion in pursuing a penalty against an insurer or in setting the penalty amount. The Department shall apply the criteria provided in Section 2591.3 of this article to determine whether a particular violation warrants an enforcement action and to determine the amount of penalty within the applicable statutory range of penalties. The provisions of this article are appropriate for determining the penalty imposed in those cases which are resolved through settlement.

(b) Enforcement action.

(1) For purposes of this article, enforcement action means any action based on an allegation by the Department that an insurer has committed a violation to which a penalty provision set forth in any of the statutes listed in subdivision (c) below applies, over the course of which action one or both of the following is to occur:

(A) The execution of a Stipulation and Consent Order or other settlement document.

(B) The issuance of a Notice of Noncompliance, Order to Show Cause, Accusation, Statement of Issues, or other legal pleading.

(2) For purposes of this article, regulatory activity such as warning letters, verbal warnings, market conduct examinations or market conduct examination reports does not constitute an enforcement action.

(c) This article applies to any insurer subject to penalty under any of the following statutes: Insurance Code sections 704.7, 769.86, 789.3, 790.035, 790.036, 790.07, 1858.07, 1858.1, 1858.3, 1859.1, 1861.14, 10140.1, 10140.5, 10149.1, 10199.7, 10234.3, 10509.9, 11756, and 12414.25.

(d) The provisions of this article are not intended to be consulted by a hearing officer, judge or trier of fact in connection with an action brought by the Department. The provisions of this article are not intended to be used in determining an appropriate settlement in connection with a settlement conference ordered pursuant to any applicable rule of court or provision of the Administrative Procedure Act. To the extent that the provisions of this article conflict with the provisions of any statute or other regulation that more specifically addresses a particular violation, this article shall be inapplicable.

NOTE: Authority cited: Sections 790.10 and 12921.1, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal.3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 704.7, 769.86, 789.3, 790.035, 790.036, 790.07, 790.10, 1858.07, 1858.1, 1858.3, 1859.1, 1861.14, 10140.1, 10140.5, 10149.1, 10199.7, 10234.3, 10509.9, 11756, 12414.25 and 12921.1, Insurance Code.

HISTORY

1. New section filed 12–15–2003; operative 1–14–2004 (Register 2003, No. 51).

§ 2591.2.

The Department shall examine the violations committed by the insurer. The Department shall take into consideration the criteria listed in Section 2591.3 and any other relevant considerations to determine if the seriousness of the insurer's act warrants an enforcement action. If after a review of those criteria the Department determines that an enforcement action is warranted, the Department shall take into consideration the criteria listed in Section 2591.3 and any other relevant considerations to determine an appropriate penalty for each act in violation of the law from within the applicable statutory penalty range or ranges. In addition to the actual penalty amount, the Department may also recover its costs associated with the enforcement action, including but not limited to attorneys' fees.

NOTE: Authority cited: Sections 790.10 and 12921.1, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal.3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 704.7, 769.86, 789.3, 790.035, 790.036, 790.07, 790.10, 1858.07, 1858.1, 1858.3, 1859.1, 1861.14, 10140.1, 10140.5, 10149.1, 10199.7, 10234.3, 10509.9, 11756, 12414.25, 12921 and 12921.1, Insurance Code.

HISTORY

1. New section filed 12–15–2003; operative 1–14–2004 (Register 2003, No. 51).

§ 2591.3.

In determining that an enforcement action should be pursued and in selecting the appropriate amount of the penalty from the applicable range of penalty amounts that could be assessed, the Department shall consider:

(a) The nature of the violation, including but not limited to adverse actions such as overcharge of premium, unlawful denials or terminations of coverage, placement in a program or tier with a higher rate level or less coverage than the most favorable for which the insured would qualify, misrepresentations of terms, unlawful denial or delay of claims, unreasonably low claims offers or settlements, improper sharing of personal information, acts of unfair competition and acts of unfair discrimination.

(b) The severity of the violation.

(1) Severity of the violation includes but is not limited to:

(A) the extent of harm revealed through a consumer complaint or otherwise brought to the attention of the Department;

(B) the amount of premium overcharge or undercharge;

(C) the amount of underpayment of a claim;

(D) a comparison of the length of the delay to the time reasonably necessary or legally required to conduct the process or transaction;

(E) the significance of the amount of premium involved in relation to the total premium for the coverage; and

(F) the significance of the amount of underpayment of the loss settlement offer or final settlement involved in relation to the total loss settlement determined to be reasonable.

(2) Consideration may also be given to the necessary complexity of the transaction.

(c) The frequency of the occurrence of the violation. In determining the frequency, consideration may be given to the number of violations specifically identified and the number of persons reasonably determined to have been impacted over a given period of time by such violations within the insurer's population of applicants, insureds, claimants, potential applicants or among its competitors and to the number of files in

which the violation takes place compared to the number of files with a similar transaction but no violation.

(d) The knowledge or willfulness of the non–compliant act.

(1) Violations that may be considered willful or knowingly committed include but are not limited to the following:

(A) When the insurer is aware at the time of the act that it is violating the law;

(B) When the insurer reasonably should have known of the act's unlawfulness when the non–compliant act occurred;

(C) When the insurer has promulgated express policies or procedures that are in noncompliance with the law;

(D) When the insurer has failed to adopt, communicate and implement reasonable standards for consistent, compliant activity; or

(E) When the insurer has failed to take effective remedial measures when a violation was identified or discovered.

(2) In the case of an employee, agent or contract entity conducting business on the insurer's behalf, knowledge or willfulness shall be attributed to the insurer unless the employee, agent or contract entity has acted outside the scope of the employment, agency or contract.

(e) The monetary effect of the violation on the insurer. For purposes of this criterion, consideration will be given to the amount of monetary gain or loss experienced by the insurer as a result of the violation.

(f) The compliance record of the insurer. The compliance record includes but is not limited to the following:

(1) The number and type of violations identified in the investigation of consumer complaints generated by the insurer over a given period of time or the number and type of violations reported in a previous examination or investigatory report;

(2) The insurer's cooperation and prompt, good–faith actions taken to provide restitution and correct any non–compliant activity including where the noncompliance is discovered and resolved prior to the Department's involvement;

(3) The insurer's failure to take action in response to previous notifications identifying the non–compliant activity;

(4) The insurer's failure to implement its express commitments to take corrective action; and

(5) Any previous action taken against the insurer.

(g) The duration of the non–compliant activity. For purposes of this criterion, consideration will be given as to whether the violation was a single event or violations continued repeatedly over a given period of time.

(h) The existence of extraordinary circumstances. Extraordinary circumstances are circumstances outside of the control of the insurer that severely and materially affect the insurer's ability to comply with the law. Extraordinary circumstances do not include circumstances which the insurer could reasonably anticipate and prepare for or prevent.

(i) Previous actions taken by the Department against other insurers for similar noncompliance. For purposes of this criterion, consideration shall be given to previous actions for similar violations by insurers of similar size and circumstance. However, such consideration shall not preclude the Department from taking an enforcement action where no previous action had been taken or from seeking an increased or decreased penalty amount relative to a previous penalty amount.

NOTE: Authority cited: Sections 790.10 and 12921.1, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal.3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 704.7, 769.86, 789.3, 790.035, 790.036, 790.07, 790.10, 1858.07, 1858.1, 1858.3, 1859.1, 1861.14, 10140.1, 10140.5, 10149.1, 10199.7, 10234.3, 10509.9, 11756, 12414.25 and 12921.1, Insurance Code.

HISTORY

1. New section filed 12–15–2003; operative 1–14–2004 (Register 2003, No. 51).

§ 2591.4.

(a) Equal consideration need not be given to each criterion described in Section 2591.3. The Department shall determine which criteria are relevant under the circumstances and shall determine the appropriate consideration to be given to those criteria. Neither inapplicability of one or more criteria nor absence of harm shall mitigate the effect of any relevant criterion.

(b) The determinations made regarding the criteria that are relevant for purposes of the decision as to whether an enforcement action is to be pursued may differ from the determinations made in the same case regarding the criteria that are relevant for purposes of the decision as to the appropriate penalty. Likewise, the amount of consideration any relevant criterion is to receive for purposes of determining whether an enforcement action is to be pursued may, in the same case, differ from the amount of consideration, if any, which that criterion is to receive for purposes of determining the appropriate penalty.

(c) In determining whether to pursue an enforcement action and in determining an appropriate penalty, the Department may, in circumstances it deems appropriate, consider matters not listed in Section 2591.3. When such other considerations enter into the settlement process, the basis for those considerations will be stated during the course of any settlement negotiations.

(d) The provisions of this article do not affect the commissioner's discretion to take any other measures such as seeking an order requiring specific corrective action, a hearing in accordance with statute, or the suspension or revocation of an entity's license or certificate of authority. Nothing in this article shall, in any manner, abridge or constitute a waiver of the attorney–client, work product, deliberative process or other privilege, or other right of confidentiality, afforded by rule, regulation, case law or statute, including but not limited to the California Evidence Code and the Federal Rules of Evidence.

NOTE: Authority cited: Sections 790.10 and 12921.1, Insurance Code; *CalFarm Insurance Company v. Deukmejian*, 48 Cal.3d 805 (1989); and *20th Century Insurance Company v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 704.7, 769.86, 789.3, 790.035, 790.036, 790.07, 790.10, 1858.07, 1858.1, 1858.3, 1859.1, 1861.14, 10140.1, 10140.5, 10149.1, 10199.7, 10234.3, 10509.9, 11756, 12414.25 and 12921.1, Insurance Code.

HISTORY

1. New section filed 12–15–2003; operative 1–14–2004 (Register 2003, No. 51).

Article 20. Standards Applicable to Workers' Compensation Claims Adjusters and Medical Billing Entities and Certification of Those Standards by Insurers

§ 2592. Authority and Purpose.

These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of Section 11761 of the California Insurance Code. The purpose of these regulations is to set forth the minimum standards of training, experience, and skill that workers' compensation claims adjusters, including adjusters working for medical billing entities, must possess to perform their duties with regard to workers' compensation claims and to specify how insurers must meet and certify those standards to the Insurance Commissioner.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New article 20 (sections 2592–2592.14) and section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.01. Definitions.

As used in this article:

(a) "Certify" means a written statement made under penalty of perjury.

(b) "Claims adjuster" means a person who, on behalf of an insurer, including an employee or agent of an entity that is not an insurer, is responsible for determining the validity of a workers' compensation claim. The claims adjuster may also establish a case reserve, approve and process all workers' compensation benefits, may hire investigators, attorneys or other professionals and may negotiate settlements of claims. "Claims adjuster" also means a person who is responsible for the immediate supervision of a claims adjuster but does not mean an attorney representing the insurer or a person whose primary function is clerical. "Claims adjuster" also includes an experienced claims adjuster. "Claims adjuster" does not

include the medical director or physicians utilized by an insurer for the utilization review process pursuant to Labor Code section 4610.

(c) "Classroom" means any space sufficiently designed so that the instructor and students can communicate with a high degree of privacy and relative freedom from outside interference. The instructor or the person or persons assisting the instructor may be physically present or may communicate with students by means of an electronic medium, including, but not limited to, audio, video, computer, or Internet.

(d) "Course" means any program of instruction taken or given to satisfy the requirements of Insurance Code Section 11761.

(e) "Curriculum" means a course of study that satisfies the requirements of Insurance Code Section 11761. The curriculum must provide sufficient content, including time allocated to each subject area, to enable claims adjusters, medical–only claims adjusters, and medical bill reviewers to meet minimum standards of training, experience, and skill to perform their duties with regard to workers' compensation claims.

(f) "Experienced claims adjuster" means a person who has had at least five (5) years within the past eight (8) years of on–the–job experience adjusting California workers' compensation claims or supervising claims adjusters handling California workers' compensation claims and is designated as an experienced claims adjuster by an insurer. A person who has successfully completed the written examination specified by Title 8, Section 15452 of the California Code of Regulations is also considered an experienced claims adjuster, provided that he or she has either (1) worked as a workers' compensation claims adjuster or supervised workers' compensation claims adjusters continuously since passing the examination and is designated as an experienced claims adjuster by an insurer or (2) passed the examination within the previous five (5) years and is designated as an experienced claims adjuster by an insurer. "Experienced claims adjuster" also includes a person who has already been trained and designated a claims adjuster and now meets the requirements of experience or examination completion noted above and is designated an experienced claims adjuster by an insurer.

(g) "Experienced medical–only claims adjuster" means a person who has had at least three (3) years within the past five (5) years of on–the–job experience adjusting California workers' compensation medical–only claims and is designated as an experienced medical–only claims adjuster by an insurer.

(h) "Experienced medical bill reviewer" means a person who has had at least three (3) years within the past five (5) years of on–the–job experience reviewing California workers' compensation medical bills and is designated as an experienced medical bill reviewer by a medical billing entity or by an insurer.

(i) "Instructor" means a person who conveys curriculum content to students on behalf of an insurer, a training entity, or a medical billing entity. An instructor shall have had at least five (5) years within the past eight (8) years of on–the–job experience adjusting California workers' compensation claims and have been designated as a claims adjuster by an insurer or be an individual who has had at least eight (8) years of experience in California workers' compensation within the past twelve (12) years. Persons knowledgeable about specific workers' compensation issues who are not instructors may train students under the direction of an instructor.

(j) "Insurer" means an insurance company admitted to transact workers' compensation insurance in California, the State Compensation Insurance Fund, an employer that has secured a certificate of consent to self–insure from the Department of Industrial Relations pursuant to Labor Code Section 3700(b) or (c), or a third party administrator that has secured a certificate of consent pursuant to Labor Code Section 3702.1.

(k) "Medical bill reviewer" means a person who is not a claims adjuster or medical–only claims adjuster and who only reviews or adjusts workers' compensation medical bills on behalf of an insurer, including employees or agents of the insurer or employees or agents of a medical billing entity. "Medical bill reviewer" also includes an experienced medical bill reviewer.

(*l*) "Medical billing entity" means a third party that reviews or adjusts workers' compensation medical bills for insurers.

(m) "Medical–only claims adjuster" means a person who, on behalf of an insurer, including an employee or agent of an entity that is not an insurer, is responsible for determining the validity of workers' compensation claims only involving medical workers' compensation benefits, as defined under Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code. The medical–only claims adjuster may also establish medical treatment reserves, approve and process medical benefits, and negotiate settlement of medical benefit claims. "Medical–only claims adjuster" also means a person who is responsible for the immediate supervision of a medical–only claims adjuster but does not mean an attorney representing the insurer or a person whose primary function is clerical. "Medical–only claims adjuster" also includes an experienced medical–only claims adjuster. "Medical–only claims adjuster" does not include the medical director or physicians utilized by an insurer for the utilization review process pursuant to Labor Code section 4610.

(n) "Post–designation training" means a course of study provided to trained or experienced workers' compensation claims adjusters and medical–only claims adjusters who have been designated by an insurer or provided to trained or experienced medical bill reviewers who have been designated by an insurer or medical billing entity. Post–designation training also includes seminars, workshops, or other informational meetings pertaining to California workers' compensation.

(o) "Student" or "trainee" means an individual taking a course that is required for that person in order to be a workers' compensation claims adjuster, medical–only claims adjuster, or medical bill reviewer.

(p) "Training" means to provide a course of instruction that includes the topics specified in Sections 2592.03 and 2592.04.

(q) "Training entity" means any person or organization that provides instructors or curriculum to an insurer or medical billing entity.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.02. Training Required for Claims Adjusters and Medical–Only Claims Adjusters.

(a) Every insurer shall require all claims adjusters and medical–only claims adjusters who handle workers' compensation claims on the insurer's behalf, other than those who are defined in subdivisions (f) and (g) of Section 2592.01, to be trained pursuant to these subparagraphs:

(1) The insurer shall require at least 160 hours of training for claims adjusters, at least 120 hours of which shall be conducted in a classroom with an instructor. The insurer shall require at least 80 hours of training for medical–only claims adjusters, at least 50 hours of which shall be conducted in a classroom with an instructor. Any training not conducted in a classroom with an instructor may be done on the job under the supervision of an instructor or an experienced claims adjuster.

(2) A medical–only claims adjuster who has completed 80 hours of training pursuant to this section may be designated as a claims adjuster upon completion of 80 additional hours of workers' compensation claims training, 70 hours of which shall be in a classroom with an instructor, provided that such training is completed within six months of the claims adjuster beginning to adjust claims that include more than medical benefits.

(b) The training required by this section shall be completed within a twelve (12) consecutive month period, during which time a claims adjuster or medical–only claims adjuster trainee may adjust claims under the supervision of an instructor or experienced claims adjuster. No individual may adjust claims on behalf of one or more insurers for a combined total of more than twelve (12) months unless such individual has been trained pursuant to this article. However, if a claims adjuster or medical–only claims adjuster trainee requires leave from his or her employment because of illness, disability, military service, or leave required or permitted by state or federal law, and the leave has begun after the

training has started, the training shall be completed within a period not to exceed 24 months after the commencement of the training.

(c) Any classes or courses taken within three (3) years before the effective date of these regulations that satisfy the curriculum requirement may be used to meet the hourly requirements upon verification by the student to the insurer of the type of course taken, the course of study, the date or dates taken, the person or organization providing the class or course, and the number of hours taken.

(d) Upon the effective date of these regulations, every insurer shall require a minimum of 30 hours of post-designation training every two (2) years for all claims adjusters and 20 hours of training every two (2) years for all medical-only claims adjusters.

(e) Post-designation training may include seminars, workshops, or other informational meetings pertaining to California workers' compensation and need not be in a classroom with an instructor. Such training shall be verified by the insurer with the type of course taken, the subject matter, the date or dates taken, the location of the training, the person or organization providing the training, and the number of hours taken.

(f) Failure of a claims adjuster or medical-only claims adjuster who has received a designation pursuant to subdivisions (a) or (b) of section 2592.05 to fulfill the requirements for post-designation training every two years pursuant to subdivisions (d) and (e) above shall result in that person being no longer considered a designated claims adjuster or medical-only claims adjuster. That person shall not be authorized to adjust claims until the requisite number of hours of post-designation training is completed.

(g) The insurer may provide the designation training directly or by sending its employees or its agents to be trained by a training entity for the entire designation curriculum. An insurer shall certify to the Insurance Commissioner that the course of instruction provided for training meets all the requirements set forth in this article and that all of the claims adjusters and medical-only claims adjusters who adjust claims on behalf of the insurer have actually attended the training for the required number of hours, in the manner provided for in sections 2592.07 and 2592.08.

(h) A claims adjuster or medical-only claims adjuster who has completed the training required by this section shall not be required to be re-trained and re-designated in order to adjust claims for a different insurer.

(i) An insurer may not authorize an individual to act in the capacity of claims adjuster or medical-only claims adjuster who has not been trained and designated pursuant to this article or who is not an experienced claims adjuster or an experienced medical-only claims adjuster and designated pursuant to this article, except that an individual who is undergoing training may adjust claims under the direct supervision of an instructor or experienced claims adjuster.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1-23-2006; operative 2-22-2006 (Register 2006, No. 4).

§ 2592.03. Curriculum.

(a) The course of study required by Section 2592.02 for claims adjusters shall include, but not be limited to, the following topics:

(1) Historical overview of the workers' compensation system.

(2) Organizational structure of the system.

(3) The workers' compensation insurance policy, its forms and endorsements, insurance principles of compensation.

(4) Concepts and terminology.

(5) Benefit provisions.

(6) Compensability.

(7) Notice requirements.

(8) Temporary disability.

(9) Permanent disability, including evaluation and rating.

(10) Death benefits.

(11) Return to work and vocational rehabilitation.

(12) Cumulative trauma.

(13) Serious and willful misconduct.

(14) Workers' Compensation Appeals Board procedures, forms, hearings, and penalties.

(15) Investigation.

(16) Fraud.

(17) Medical terminology.

(18) Knowledge and use of utilization guidelines (American College of Occupational and Environmental Medicine or other guidelines approved by the Administrative Director of the Division of Workers' Compensation.)

(19) Medical evidence.

(20) Medical dispute resolution (Qualified Medical Examiners, spinal surgery second opinions, pre-designation of physicians, independent medical reviewers, utilization review.)

(21) Fee schedules.

(22) Liens.

(23) Apportionment.

(24) Subrogation.

(25) Reserving.

(26) Ethical issues.

(b) The course of study required for the training of medical-only claims adjusters shall include, at a minimum, all the topics specified in subdivision (a) above, with the exception of (8), (9), (10), (11), (13), and (23).

(c) The course of study required by Section 2592.02(d) for post-designation training shall include changes in the law that affect workers' compensation claims and any other topics relevant to the work of a claims adjuster or medical-only claims adjuster as specified in subdivision (a) above.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1-23-2006; operative 2-22-2006 (Register 2006, No. 4).

§ 2592.04. Training Required for Medical Bill Reviewers.

(a) Every insurer shall require all medical bill reviewers, other than those defined in section 2592.01(h), including employees and agents of medical billing entities used by the insurer, to be trained. The insurer shall require at least 40 hours of training for medical bill reviewers, at least 30 hours of which shall be conducted in a classroom by an instructor. No more than ten (10) hours of training may be done on the job.

(b) The training required by this section shall be completed within a twelve (12) month period, during which time a medical bill review trainee may review bills under the supervision of an instructor, experienced medical bill reviewer, or experienced claims adjuster. No individual may review medical bills on behalf of one or more insurers for a combined total of more than twelve (12) months unless the individual has been trained pursuant to this article.

(c) Any classes or courses taken within one (1) year before the effective date of these regulations that satisfy the curriculum requirement of subdivision (h) below may be used to meet the hourly requirements upon verification by the student to the insurer or medical billing entity of the type of course taken, the course of study, the date or dates taken, the person or organization providing the class or course, and the number of hours taken.

(d) Upon the effective date of these regulations, every insurer shall require a minimum of 16 hours every two (2) years of post-designation training for all medical bill reviewers and shall include in the post-designation training changes in the law affecting medical bill reviewers and topics as specified in subdivision (h) below.

(e) Failure of a medical bill reviewer designated pursuant to subdivisions (a) or (c) of section 2592.05 to fulfill the requirements for post-designation training every two years pursuant to subdivision (d) above shall result in that person being no longer considered a designated medical bill reviewer. That person shall not be authorized to review medical bills until the requisite number of hours of post-designation training is completed.

(f) The insurer may provide the designation training directly or by sending its employees or agents to be trained by a training entity for the

entire designation curriculum. The insurer shall require all medical billing entities that review or adjust medical billings on its behalf to have the medical billing entities' employees or agents trained directly by the medical billing entity, the insurer, or by a training entity for the entire designation curriculum. The insurer shall certify, in the manner provided for in sections 2592.07 and 2592.09, that the course of instruction provided or that is provided by its medical billing entities meets all the requirements set forth in this article and that all medical bill reviewers of the insurer and its medical billing entities have actually attended the training for the required number of hours.

(g) A medical bill reviewer who has received a Designation as having completed the training required by this article shall not be required to be re–trained and re–designated in order to review medical bills for a different insurer.

(h) The curriculum for the training of medical bill reviewers shall include, but not be limited to, the following topics:

(1) The correct use of billing codes and detection of improper use of billing codes.

(2) All fee schedules applicable in California to workers' compensation medical care, including statutes and regulations authorizing the fee schedules.

(3) Workers' compensation benefit provisions.

(4) Fraud.

(5) Medical terminology.

(6) Utilization guidelines (American College of Occupational and Environmental Medicine or other guidelines approved by the Administrative Director of the Division of Workers' Compensation.)

(7) Medical evidence.

(8) Liens.

(9) Ethical issues.

(i) An insurer may not authorize an individual to act in the capacity of a medical bill reviewer who has not been trained pursuant to this article or who is not an experienced medical bill reviewer, except that an individual who is undergoing training may review medical bills under the direct supervision of an instructor, experienced medical bill reviewer or experienced claims adjuster.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.05. Designation.

(a) A Designation shall be provided by the insurer to any person who successfully completes the claims adjuster, medical–only claims adjuster, or medical bill reviewer training required by sections 2592.02 and 2592.03 or section 2592.04, respectively. The Designation for a claims adjuster, medical–only claims adjuster or a medical bill reviewer shall be in the form specified in Section 2592.10 or 2592.11, respectively.

(b) An Experienced Claims Adjuster or Experienced Medical–Only Claims Adjuster Designation shall be provided by the insurer to a person as defined in Section 2592.01(f) or (g), respectively. The Experienced Claims Adjuster or Experienced Medical–Only Claims Adjuster Designation shall be in the form specified in Section 2592.12.

(c) An Experienced Medical Bill Reviewer Designation shall be provided by the insurer to a person as defined in Section 2592.01(h). The Experienced Medical Bill Reviewer Designation shall be in the form specified in Section 2592.13.

(d) An insurer shall provide to the claims adjuster, medical–only claims adjuster or medical bill reviewer a Post–Designation Training Form that states the course and hours taken for the post–designation training following the completion of the required training. The Post–Designation Training Form shall be on the form specified in Section 2592.14.

(e) A medical billing entity may provide medical bill reviewer and experienced medical bill reviewer Designations and Post–Designation Training Forms to its employees or agents that meet the requirements of this article so long as the insurer using the medical billing entity confirms that the medical billing entity has met all requirements of this article and obtains copies of all records required by this article.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.06. Maintenance of Records.

(a) An insurer shall maintain copies of the Designation forms pertaining to trained and experienced claims adjusters, medical–only claims adjusters and medical bill reviewers in its employ or acting on its behalf, notwithstanding whether or not that person was designated by it or was employed or trained by or on behalf of another insurer or a medical billing entity, as long as the claims adjuster, medical–only claims adjuster, or medical bill reviewer is in its employ or acting on its behalf and thereafter for five (5) years.

(b) An insurer shall maintain copies of the Post–Designation Training Forms as long as the claims adjuster, medical–only claims adjuster, or medical bill reviewer is in its employ or acting on its behalf, notwithstanding whether or not that person received post–designation training by that insurer or was employed or trained by or on behalf of another insurer or medical billing entity, and thereafter for five (5) years.

(c) If a trained or experienced claims adjuster, medical–only claims adjuster, or medical bill reviewer is employed by or works on behalf of an insurer that did not designate him or her, the insurer that did designate the claims adjuster, medical–only claims adjuster, or medical bill reviewer shall send copies of the Designation Forms to the current insurer within 20 working days after a request for the Designation Forms has been received.

(d) All insurers shall maintain a record of all courses given or taken by claims adjusters, medical–only claims adjusters, or medical bill reviewers to comply with this article. The record shall include:

(1) The name and business address of all students, along with the beginning and ending date of the training of the student and a statement of whether or not the student has completed the training in all topic areas required to be covered.

(2) A complete description of the curriculum, including all topics covered with a detailed statement of how much time was spent training students in each topic, the name of the entity providing the instruction, and the name of the instructor or instructors and any persons who instructed under the direction of the instructor.

(e) All insurers shall maintain a record of all post–designation courses, seminars, workshops, or other training taken by claims adjusters, medical–only claims adjusters, and medical bill reviewers employed by or acting on their behalf. The record shall also include the dates of such training, the time spent in the training, and the topics covered.

(f) All records maintained pursuant to this article shall be made available to the Insurance Commissioner and to the Administrative Director of the Division of Workers' Compensation. Copies of all Designation Forms maintained pursuant to the article and issued to a claims adjuster, medical–only claims adjuster, or medical bill reviewer shall be provided by the insurer that issued the forms to that person within 20 working days of a request for copies of the forms from the claims adjuster, medical–only claims adjuster, or medical bill reviewer.

(g) Upon the request of a policyholder or an injured worker whose claim is being adjusted, the insurer shall provide to the requesting policyholder or injured worker a copy of the Designation Form of the claims adjuster, medical–only claims adjuster, or medical bill reviewer handling the claim demonstrating that person's qualifications in adjusting that claim.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.07. Certification and Submission of Documents.

(a) Each insurer shall submit to the commissioner annually by July 1 of each year a document certifying the following:

(1) the total number of persons adjusting claims on its behalf;

(2) the total number of claims adjusters and medical–only claims adjusters who are trained or experienced;

(3) the percentage of the claims adjusters and medical–only claims adjusters who are trained or experienced;

(4) all persons adjusting claims on behalf of the insurer are designated to do so or are in training; and

(5) the course of instruction provided for training of all claims adjusters and medical–only claims adjusters meets all requirements of this article and that all claims adjusters and medical–only claims adjusters have attended training for the required number of hours to be qualified to adjust workers' compensation claims.

The document, which shall be on the form specified in Section 2592.08, shall be signed under penalty of perjury by the person or executive officer responsible for the insurer's claims operations. The commissioner shall publish the information contained in this document on the Department of Insurance public website.

(b) Each insurer shall submit to the commissioner annually by July 1 of each year a document certifying the following:

(1) the total number of medical bill reviewers reviewing medical bills on its behalf;

(2) the total number of medical bill reviewers who are trained or experienced;

(3) the percentage of the medical bill reviewers who are trained or experienced medical bill reviewers;

(4) all persons reviewing medical bills on its behalf are designated to do so or are in training; and

(5) the course of instruction provided for training of all medical bill reviewers of the insurer and of medical billing entities used by the insurer meets all requirements set forth in this article and that all medical bill reviewers of the insurer and of medical billing entities used by the insurer have attended training for the required number of hours to be qualified to perform medical bill review.

The document, which shall be on the form specified in Section 2592.09, shall be signed under penalty of perjury by the person or executive officer responsible for the insurer's claims operations. The commissioner shall publish the information contained in this document on the Department of Insurance public website.

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.08. Insurer Annual Certification Form—Claims Adjusters and Medical–Only Claims Adjusters.

ANNUAL CERTIFICATION OF CLAIMS ADJUSTERS AND MEDICAL–ONLY CLAIMS ADJUSTERS

To the Insurance Commissioner of the State of California
Pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Sections 2592.02 and 2592.07

As the person or officer responsible for the claims operation of:

_____
(Name of Insurer)

☐ Insurance Company ☐ Self–Insured Employer
☐ Third–Party Administrator
(Check One)

I hereby certify the following regarding California workers' compensation claims:

1. The total number of persons adjusting claims on this insurer's behalf is: _____.

2. The total number of experienced or trained claims adjusters and medical–only claims adjusters adjusting claims on the insurer's behalf is: _____.

3. The percentage of experienced or trained claims adjusters and medical–only claims adjusters adjusting claims on the insurer's behalf is: _____%

4. All persons adjusting claims on behalf of this insurer are designated to do so or are in training.

5. The course of instruction provided for training of all claims adjusters and medical–only claims adjusters meets all requirements set forth in Article 20 (commencing with section 2592) of Subchapter 3, Chapter 5, Title 10, California Code of Regulations, and that all claims adjusters and medical–only claims adjusters have attended training for the required number of hours to be qualified to adjust workers' compensation claims.

I certify under the penalty of perjury under the laws of the State of California that the foregoing is true and correct:

_____ _____
(Date and Place) (Signature)

Name of person certifying (print or type):

Title of person certifying:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.09. Insurer Annual Certification Form—Medical Bill Reviewers.

ANNUAL CERTIFICATION OF MEDICAL BILL REVIEWERS

To the Insurance Commissioner of the State of California
Pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Sections 2592.04 and 2592.07

As the person or officer responsible for the claims operation of:

_____
(Name of Insurer)

☐ Insurance Company ☐ Self–Insured Employer
☐ Third–Party Administrator
(Check One)

I hereby certify the following regarding California workers' compensation claims:

1. The total number of medical bill reviewers reviewing medical bills on this insurer's behalf is: _____.

2. The total number of experienced or trained medical bill reviewers reviewing medical bills on this insurer's behalf is: _____.

3. The percentage of experienced or trained medical bill reviewers reviewing medical bills on this insurer's behalf is: _____%

4. All persons reviewing medical bills on behalf of this insurer are designated to do so or are in training.

5. The course of instruction provided for training of all medical bill reviewers of this insurer and of medical billing entities used by this insurer meets all requirements set forth in Article 20 (commencing with section 2592) of Subchapter 3, Chapter 5, Title 10, California Code of Regulations, and that all medical bill reviewers of this insurer and of medical billing entities used by this insurer have attended training for the required number of hours to be qualified to perform medical bill review.

I certify under the penalty of perjury under the laws of the State of California that the foregoing is true and correct:

_____ _____
(Date and Place) (Signature)

Name of person certifying (print or type):

Title of person certifying:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.10. Designation—Claims Adjuster and Medical–Only Claims Adjuster.

CLAIMS ADJUSTER or MEDICAL–ONLY CLAIMS ADJUSTER DESIGNATION

This Designation is awarded to

_____

(Adjuster's Name)

for: ☐ Claims Adjuster ☐ Medical–Only Claims Adjuster

(Check Only One)

as a result of successfully completing the required hours for workers' compensation training pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Sections 2592.02 and 2592.03

Total Hours of Training Completed: _____

Designation Given By:

_____

(Name of Insurance Company, Self–Insured Employer, or Third–Party Administrator)

_____ _____

(Date) (Signature)

Name of person awarding designation (print or type):

Title of person awarding designation:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.11. Designation—Medical Bill Reviewer.

MEDICAL BILL REVIEWER DESIGNATION

This Designation is awarded to

_____

(Medical Bill Reviewer's Name)

for Medical Bill Reviewer Training

as a result of successfully completing the required hours for workers' compensation training pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Section 2592.04

Total Hours of Training Completed: _____

Designation Given By:

_____

(Name of Insurer or Medical Billing Entity)

_____ _____

(Date) (Signature)

Name of person awarding designation (print or type):

Title of person awarding designation:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.12. Designation—Experienced Claims Adjuster and Medical–Only Claims Adjuster.

EXPERIENCED CLAIMS ADJUSTER OR EXPERIENCED MEDICAL–ONLY CLAIMS ADJUSTER DESIGNATION

This Designation is awarded to

_____

(Adjuster's Name)

for: ☐ Experienced Claims Adjuster

☐ Experienced Medical–Only Claims Adjuster

(Check Only One)

as a result of meeting the experience requirements for workers' compensation claims experience pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Sections 2592.01 and 2592.05

Total Years of California Experience At Time of Designation: _____

and/or

Date Completed Examination Pursuant to Title 8, CCR Section 15452: _____

Designation Given By:

_____

(Name of Insurance Company, Self–Insured Employer, or Third–Party Administrator)

_____ _____

(Date) (Signature)

Name of person awarding designation (print or type):

Title of person awarding designation:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.13. Designation—Experienced Medical Bill Reviewer.

EXPERIENCED MEDICAL BILL REVIEWER DESIGNATION

This Designation is awarded to

_____

(Medical Bill Reviewer's Name)

for Experienced Medical Bill Reviewer

as a result of meeting the requirements for workers' compensation medical bill reviewing experience pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Sections 2592.01 and 2592.05

Total Years of California Experience At Time of Designation: _____

Designation Given By:

_____

(Name of Insurer or Medical Billing Entity)

_____ _____

(Date) (Signature)

Name of person awarding designation (print or type):

Title of person awarding designation:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

§ 2592.14. Post–Designation Training Form.

POST–DESIGNATION TRAINING FORM

_____

(Adjuster's or Medical Bill Reviewer's Name)

☐ Claims Adjuster ☐ Medical–Only Claims Adjuster
☐ Medical Bill Reviewer

(Check Only One)

has successfully completed the post–designation workers' compensation training and hours noted below pursuant to California Insurance Code Section 11761 and California Code of Regulations, Title 10, Sections 2592.02 , 2592.03, 2592.04, and 2592.05

Name and Topic of Post–Designation Training Taken:

_____

Total Hours of Post–Designation Training Completed: _____

Date of Post–Designation Training: _____

Post–Designation Training Verified By:

_____

(Name of Insurer or Medical Billing Entity)

_____ _____

(Date) (Signature)

Name of person awarding designation (print or type):

Title of person awarding designation:

Business address:

NOTE: Authority cited: Section 11761, Insurance Code. Reference: Section 11761, Insurance Code.

HISTORY

1. New section filed 1–23–2006; operative 2–22–2006 (Register 2006, No. 4).

[The next page is 679.]

Subchapter 4. Insurer Securities Permits

Article 1. General Provisions

§ 2600. Authority for Regulations.

These regulations are promulgated pursuant to the rule–making power conferred upon the Insurance Commissioner by the Legislature in Section 843 of the Insurance Code (formerly Political Code Section 594c; Chapter 730, page 1355, Stats. 1929). Any express statutory basis for each regulation is cited either at the end of each section hereof or after that portion of a section to which it particularly relates, whichever is more appropriate. All statutory references herein are to the California Insurance Code unless otherwise stated.

NOTE: Authority cited for new Subchapter 4: Section 843, Insurance Code.

HISTORY

1. Repealer of former Subchapter 4 (Sections 2600 through 2680) and new Subchapter 4 (2600, 2601, 2601–2601.04, 2602.01–2602.09, 2603.01–2603.21, 2604.01–2604.07, 2605.01–2605.06, 2606.01–2606.03, 2607.01–2607.06, 2608.01–2608.08, 2609.01–2609.08, 2610.01–2610.03, 2611.01–2611.03, 2612.01–2612.05, 2613.01–2613.08) filed 12–1–66; effective thirtieth day thereafter (Register 66, No. 42). For history of former Subchapter 4, see Registers 58, No. 17, and 59, Nos. 2 and 3.

§ 2601. Citation.

These regulations may be referred to and cited as the Insurer Securities Permit Regulations; the abbreviated citation is ISPR.

§ 2601.01. Purpose.

The object of these regulations is to provide in a readily accessible form for the guidance and assistance of all who are subject to, practice under or administer the Insurance Securities Law the principal requirements of substance and procedure governing applications for and the granting of insurer securities permits.

It is impossible to foresee every contingency and provide a regulation in anticipation thereof. These regulations are designed to be applied to the situations most frequently arising under that portion of the Insurance Securities Law governing applications for and issuance of insurer securities permits. They shall not contravene or curtail any statute. Furthermore, the duties and discretion of the Insurance Commissioner conferred upon him by statute in administering the Insurance Securities Law are not and cannot be exhausted by these regulations. Each application will continue to be analyzed individually and judged on its own merits, in the lawful discretion of the Commissioner, after application of the provisions of the Insurance Securities Law.

§ 2601.02. Definitions.

A. "Commissioner" means the Insurance Commissioner of the State of California (Section 20)

B. "Department" means the Insurance Department of the State of California as constituted by statute. (Sections 21 and 12906)

C. "Insurer" for the purpose of these rules includes every organization organized for the purpose of assuming the risk of loss under contracts of insurance or reinsurance, and also includes any of the following organizations:

1. An admitted insurer;
2. A nonadmitted domestic insurer;
3. A nonadmitted foreign insurer;
4. A nonadmitted alien insurer;
5. An underwritten title company, or an organization organized for the purpose of doing an underwritten title business, whether licensed or not;
6. An attorney–in–fact of a reciprocal or interinsurance exchange, whether it be admitted or not, or an organization organized for the purpose of acting as the attorney–in–fact of a reciprocal or interinsurance exchange, whether the same be admitted or not; and

D. "Security" means every instrument commonly known by that term, including but not limited to the instruments enumerated in Section 821.5, but excepting the commercial paper, promissory notes and mortgage participation certificates described in Section 821.

E. "Insurer security permit" is used in these regulations to describe any and all types of security permits applied for by or issued to an "insurer" as that term is defined by Insurance Code Section 826 (See paragraph C of this Section 2601.02) irrespective of whether the applicant is or will be engaged in issuing contracts of insurance.

F. "Insurance company" as used in these regulations means an entity engaged or to be engaged in the business of assuming the risk of loss under contracts of insurance.

G. "Insurance" includes reinsurance.

NOTE: Authority cited: Section 843, Insurance Code. Reference: Sections 820–860, Insurance Code.

HISTORY

1. Repealer of subparagraph 7 of subsection C filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2601.03. Terminology in General.

Unless the context otherwise requires, the terminology and nomenclature used throughout these rules are the same as in the Insurance Code of the State of California. See especially Sections 1 to 42, inclusive, ib. containing definitions; also Sections 101 to 123 ib. defining classes of insurance. Words of art are used with the meaning currently attributable to them in the insurance industry.

§ 2601.04. Offices.

Insurance Code Section 12905 specifies that "The Commissioner shall keep his office in the City of San Francisco and shall also keep an office in the City of Sacramento and an office in the City of Los Angeles." Office addresses of the Department are:

100 VAN NESS AVENUE
SAN FRANCISCO, CALIFORNIA 94102

600 SO. COMMONWEALTH AVENUE
LOS ANGELES, CALIFORNIA 90005

700 L STREET, 3RD FLOOR
SACRAMENTO, CALIFORNIA 95814

1350 FRONT STREET, ROOM 3020
SAN DIEGO, CALIFORNIA 92101

NOTE: Authority cited: Section 843, Insurance Code. Reference: Sections 820–860, Insurance Code.

HISTORY

1. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

Article 2. The Insurance Securities Law (Insurance Code Sections 820–860)

§ 2602.01. Stock Permit Jurisdiction.

The insurance Securities Law applies to the original issue of their own securities anywhere (including sale of treasury stock) by domestic insurers. It applies to foreign and alien admitted and nonadmitted insurers alike wherever acts concerning the original issue of their own securities to which jurisdiction of this sovereign state attaches are performed within the state. It also forbids certain secondary sales as hereinafter explained. Except as provided by Insurance Code Sections 845, 12393 and 12395, and Financial Code Sections 350–407 (especially Sec. 402) with respect to a title insurer doing or preparing to do a trust business, there is not an overlapping or dual jurisdiction with any other agency. If the applicant is an "insurer" and if it is to "offer for sale, negotiate for the sale of, or take subscriptions for any security of its own issue" (except upon a sale pursuant to Sections 2700 et seq., Corporations Code, for delinquent assessment) within the meaning of Section 827, the Corporate Securities Law does not apply. See Corporations Code Section 25100(h). Underwritten title companies, attorneys–in–fact for reciprocals, and exclusive management corporations for domestic insurers are included in the definition of "insurer." Refer to Insurance Code Section 826 and to Section 2601.02C, supra, for definition. Choice of the wrong agency for issuance of insurer security permits will apparently result in issue of void securi-

ties, according to statute (Sections 826, 827, 831 and Corporations Code Section 25100(h)), unless and until such issue is subsequently validated by legislative act.

§ 2602.02. Secondary Sales of Securities.

Section 845 of the Insurance Code prohibits sale or resale of any security of a domestic, foreign, or alien insurer (as "insurer" is defined by Section 826 ib.; compare Paragraph C of Section 2601.02 of these regulations) as an agent of an insurer, as a broker or an agent of a broker, except under the authority therein specified; and it describes the conditions under which resale by a bona fide owner is valid.

The statute provides:

845. (a) No person may sell or resell any security of a domestic, foreign, or alien insurer:

(1) As an insurer with respect to securities of its own issue without securing the permit of the Commissioner as provided in this article.

(2) As an agent of such insurer except under authority of a certificate issued by the Commissioner under this code.

(3) As a broker or as an agent for a broker except under authority of a certificate or license issued by the Commissioner of Corporations under the provisions of the Corporations Code and in full conformity with all provisions of the Corporations Code.

(b) Subdivision (a) shall not prohibit a bona fide owner of securities of an insurer from selling or reselling such securities if:

(1) Such securities were originally issued under the authority of a permit of the Commissioner and such sale or resale is made in conformity with the conditions, if any, in such permit effective at the time of such sale or resale; or

(2) Such securities were originally issued in a jurisdiction other than California in full conformity with the applicable laws, if any, governing such issuance in such jurisdiction.

A sale or resale of securities of an insurer by the owner of the securities which is made for the purpose of evading the provisions of this article requiring an insurer to secure a permit from the Commissioner or for any other fraudulent purpose shall, however, be null and void and a violation of the criminal provisions of this article.

(c) Any sale or resale permitted by this section is subject to the stop power of the Commissioner under Section 854 and the similar powers of the Commissioner of Corporations pursuant to the provisions of the Corporations Code.

(d) Any violation of this section is subject to the penalties provided in Section 833.

NOTE: Authority cited: Section 843, Insurance Code.

HISTORY

1. Amendment filed 12–20–67; effective thirtieth day thereafter (Register 67. No. 51).

§ 2602.03. Secondary Sales by Person Acting as an Agent, Broker, or Agent of a Broker.

HISTORY

1. Repealer filed 12–20–67; effective thirtieth day thereafter (Register 67. No. 51).

§ 2602.04. Where Applicable.

The Insurance Securities Law (Insurance Code Sections 820–860) literally applies and requires the Commissioner's permit for any of the following to be done in this State: solicitation, sale or issuance of its securities by any insurer when such sale is an original issue not a secondary sale. Refer to Code Sections 821.5, 822, 827, and Opinion of California Attorney General No. 50/70, June 22, 1951, 17 Opinions California Attorney General 217, the cases cited therein and any subsequent decisions bearing on the subject. In addition, the matter of "commercial domicile" of a foreign corporation in this State may be determinative. See *Western Air Lines* vs. *Sobieski* (2nd District Court of Appeals—4/20/61), 12 Cal. Rptr. 719, 191 Cal. App. 2d 399.

§ 2602.05. When Permit Required—In General.

A permit is necessary for the sale by an insurer in this state of its treasury shares. A permit is required of domestic insurers, but is not normally required of foreign insurers, for stock splits, stock dividends, and amending articles of incorporation so as to change the rights, preferences and privileges or restrictions on outstanding securities. (There is no provision in the Insurance Securities Law comparable to subparagraphs (a) through (d) of Corporations Code Section 25500.) Insurers are further advised that in the opinion of this Department a permit is required where any of the following to be done by or on behalf of an insurer in connection with the original issue of its own securities will take place within the state: solicitation of the sale and purchase of a security; any act essential to sale or issuance of a security. Reference is suggested to the relevant court decisions, including *Western Air Lines* vs. *Sobieski*, 12 Cal. Rptr. 719, 191 Cal. App. 2d 399. (Secs. 821.5, 822, 827, 17 Ops. Cal. Atty. Gen. 217.)

§ 2602.06. When Permit Required—Mergers.

A. In case of a merger, an appropriate permit should be and customarily is obtained *before* any of the following are mailed in or into this state by the proposed issuer or anyone on its behalf to its own or any other constituent's stockholders: proxy statement or offering circular, proxy, fractional share buy and sell order form, letter of tender of shares for surrender and exchange. The proxy statement is the primary sales document and, as a practical matter, it is impossible to separate the solicitation for votes respecting the merger from solicitation for exchange of shares. (Sections 821.5, 822, and 827) Irrespective of the fact that the entire transaction may be conducted by use of the United States mail (interstate commerce), the foregoing rule represents the regular practice before this department and should be followed in order to cope with factual situations which may otherwise invalidate the issue of shares.

B. Where a merger will change the rights, privileges or preferences of California stockholders, a domestic insurer shall, and a foreign insurer ought to, procure an appropriate permit prior to soliciting California stockholders of itself or of a proposed constituent corporation to the merger. (Sections 821.5, 822, and 827). It is permissible for both constituents to join in the one application under most circumstances.

§ 2602.07. Effect of Sale Without Permit.

The law provides that issuance of a security by an insurer without a permit in force at the time of issuance, under the circumstances such that one is required, shall be void. Every security issued by an insurer under the Commissioner's permit shall be void unless its provisions conform to the provisions, if any, required by the permit. (Sec. 831) *Cf. Reed* vs. *Norman* (1953) 41 Cal. 2d 17, 256 Pac. 2d 930; *Wells* vs. *Comstock* (1956) 46 Cal. 2d 528, 531, 297 Pac. 2d 961. An insurer is itself responsible for making a correct determination of whether under the circumstances a permit is required.

§ 2602.08. Penalty for Unauthorized Sale by Insurer.

For an insurer to sell or issue a security not in conformity with the Commissioner's permit, or contrary to the Insurance Securities Law, is a public offense and punishable by a fine not exceeding $10,000. (Section 832)

§ 2602.09. Penalty for Unauthorized Sale by Individual.

Every person who knowingly authorizes, directs, aids, causes or assists in causing the issue, execution or sale of any security in nonconformity with a Commissioner's permit then in effect and authorizing such issue, or contrary to the provision of the Insurance Securities Law, is guilty of a public offense punishable by a fine not exceeding $5,000 or by imprisonment in the state prison not exceeding five years or in a county jail not exceeding one year, or by both such fine and imprisonment. (Section 833)

Article 3. Applications—In General

§ 2603.01. Made by Whom.

Unless otherwise specified by statute or these regulations, an application for an insurer securities permit shall be made as follows:

A. Where an existing insurer, as defined by paragraph C of Section 2601.02, supra, proposes to sell and issue its securities, by the insurer entity.

B. For a preorganization permit, by the individual or individuals seeking to organize the insurer.

C. For a subscription permit, by the corporate entity which seeks to solicit subscriptions for its stock.

D. For a negotiating permit, by the insurer which seeks directly or indirectly to solicit, offer, sell and issue or exchange its securities. See also Section 2602.06A, supra.

E. For a permit to solicit powers of attorney and applications for policies of insurance to organize a reciprocal insurer pursuant to Insurance Code Section 1511, by its Attorney–in–Fact. (Section 1322)

F. For a permit authorizing a reciprocal insurer to issue its securities, by the interinsurance exchange itself.

§ 2603.02. Where Filed.

Subject to specific directives of the Commissioner or assignment of companies for cause, the following will otherwise govern:

A. Admitted domestic insurers whose home offices are south of the north border of San Luis Obispo, Kern and San Bernardino Counties or in Mono or Inyo Counties shall apply through the Commissioner's Los Angeles office; other admitted domestic insurers shall apply through the Commissioner's San Francisco office. Applications for securities permits will not be accepted for filing at the Sacramento and San Diego offices.

B. Nonadmitted domestic applicants seeking organizational or similar permits shall file according to the foregoing rule applied to where their principal California offices will be when they are organized and admitted.

C. Admitted foreign insurers shall apply through the appropriate filing office determined by applying the rule of paragraph A above to their principal California base of operations, unless activities of affiliates predominant in the group are centered in another part of the state, in which event they shall file in the Commissioner's appropriate office in such other part of the state.

D. Nonadmitted foreign insurers shall file in the San Francisco office unless they have an application for Certificate of Authority pending in, or have previously applied for admission or a permit through, the Los Angeles office, in which event they shall apply through that office. (Section 843)

E. The Commissioner reserves the right to transfer an application from one office to another for the convenience of the Department or for cause.

§ 2603.03. Description of Physical Requirements.

An application for an insurer securities permit shall be typewritten in the English language on 8–1/2″ x 13″ paper. They shall be substantially in the form prescribed by this Article. Applications filed in the Los Angeles office shall be in duplicate. Applications filed in the San Francisco office may be in singular copy only.

The ribbon copy shall be bond; the carbon copy shall be on paper of a weight not less than 11 pounds per ream. Both copies shall be stapled securely at the upper left and upper right corners. There shall be no staple, rivet or other device in the upper central portion of the page which will interfere with punching for clipping the application into a manila folder with an Acco fastener. Use of an attorney's "legal back" or cover of heavy paper is unnecessary and is discouraged except in the case of bulky applications (more than 15 pages in length) that reasonably need a durable binding.

An "application" within the meaning of these regulations includes the formally entitled, captioned and duly verified typewritten allegations and request (prayer) described in this Article, together with the exhibits attached thereto or referred to and incorporated therein.

§ 2603.04. Name and Address of Legal Counsel.

The office address of any legal counsel representing applicant in the application matter shall plainly appear on the first page of the application or on the letterhead of the letter transmitting it for filing.

§ 2603.05. Substitution of Legal Counsel—Warrant of Authority.

In the event of appearance of new legal counsel after the filing of the initial application, authentic written authority from applicant for the appearance or substitution, as the case may be, shall accompany the first paper filed by the new or substituted attorney at law or shall be presented at his earliest appearance, whichever shall first occur. Whenever it appears that two or more different attorneys at law (exclusive of "House Counsel") or other attorneys, or firms of attorneys at law are filing or have filed papers or originated correspondence on behalf of an applicant, the Commissioner reserves the right to require a warrant of authority from any or all of such attorneys before recognizing or responding to such papers or correspondence.

§ 2603.06. File Number.

Every application duly filed will be assigned a number in the office where it is filed. Applicant will be notified of the file number assigned and all subsequent correspondence relating thereto shall bear such file number.

§ 2603.07. Caption.

Every application for an insurer securities permit shall be captioned thusly:

BEFORE THE DEPARTMENT OF INSURANCE
OF THE
STATE OF CALIFORNIA

§ 2603.08. Entitlement.

Every application for an insurer securities permit shall be appropriately entitled below the caption. An example of the most common entitlement is:

BEFORE THE DEPARTMENT OF INSURANCE
OF THE
STATE OF CALIFORNIA

In the Matter of the Application of ABC INSURANCE COMPANY Sacramento, California For a Permit to Offer and Sell Shares of its Capital Stock.	File No. _____ Filed _____ APPLICATION FOR PERMIT

For additional examples refer to the composite sample forms of applications in the addenda to these regulations.

§ 2603.09. Name or Label.

Every application for an insurer securities permit shall be descriptively named or labeled so as to identify its nature, e.g.: "Application for Preorganization Permit," "Application for Subscription Permit," "Application for Organizational Permit" (for initial sale of stock), "Application for Negotiating Permit," and in all cases where a definitive permit is sought, "Application for Permit." Such descriptive names or labels shall be placed preferably opposite and to the right of the box containing the entitlement, unless space does not permit. In such latter event the label may be typed across the center of the page below the entitlement and file number and above the opening paragraph of the body of the paper in capital letters.

Applications filed subsequently to the original shall be appropriately identified, e.g.: "First (Second, or Third, etc.) Supplemental Application for Permit," "Application for Third Amendment to Permit," or "First Supplement to Application for Third Amendment to Permit," etc.

§ 2603.10. Verification.

Insurance Code Section 834 requires that the application shall be verified as required by the Code of Civil Procedure. All material information submitted shall be verified; otherwise it may be regarded as having no probative value.

When an application is executed in this state or in another state whose law is similar to the California statute on the subject, the truth of the allegations made may either be verified under oath or certified to under penalty of perjury (Code of Civil Procedure Sections 446 and 2015.5); otherwise, it shall be duly sworn to under oath before a public officer lawfully authorized to administer oaths and his certificate evidencing such fact shall be attached thereto. Applications and reports of transaction not verified in accordance with law will be rejected.

An acceptable form of California verification is:

"State of California }
County of San Mateo } ss

John Smith, the undersigned, hereby certifies under penalty of perjury that he is the President of ABC Insurance Company, applicant in the foregoing application; that he has read the said application and knows the contents thereof and that the same are true of his own knowledge.

Dated this ____ day of _____, 19__, at Redwood City, California.

/s/*John Smith*_____
/t/John Smith, President"

An acceptable form of verification by a foreign applicant is as follows:

"State of Illinois }
County of Cook } ss

John Smith, first being duly sworn, deposes and says that he is the President of ABC Insurance Company, applicant in the foregoing application; that he has read the said application and knows the contents thereof and that the same are true of his own knowledge.

/s/*John Smith*_____
/t/John Smith, President

Subscribed and sworn to before me
this _____day of _____,19___.
/s/_____(Notarial Seal)
Notary Public in and for said
County and State

My commission expires_____"

The examples set forth above do not forbid verification of certain allegations on the basis of affiant's information and belief where this is permissible according to all; nor do they preclude verification by an attorney at law under the circumstances and in the manner provided by law; but an application containing allegations requiring proof before a permit is issued and verified wholly on the basis of information and belief will not be accepted; or, if accepted, will not be acted on favorably without independent satisfactory proof of the essential allegations thereof and the pertinent supporting data.

§ 2603.11. Legal Style; Prayer.

An application for an insurer securities permit shall assume the form of a sound legal pleading; it shall allege the facts essential to jurisdiction, the information required by the Insurance Code and these regulations, and (except in the case of applications for preorganization, subscription or certain negotiating permits) such additional facts and data as are reasonably necessary to enable the Commissioner to make the findings required by Section 839 and, when so requested by the Commissioner, Section 839.1.

Each such application shall conclude with an appropriate request that a permit issue, specifying what is sought to be authorized thereby, the number and description of shares or other securities asked to be authorized, the selling price thereof, and for what period of time the permit is warranted, giving commencement and termination dates where feasible. (Section 843)

§ 2603.12. Formal Allegations and Exhibits Required for All Applications.

Unless otherwise provided by these regulations or permitted by statute, every application for an insurer securities permit shall conform to the basic requirements prescribed in this section. It shall set forth, either in the body of the application or by appropriate exhibits attached thereto and incorporated therein by reference, the information and data specified in paragraphs A. through D. of this section. It shall also be supported by the items described in paragraphs E. through M. hereof. Such latter items may be attached as exhibits and appropriately referred to and incorporated in the body of the application. (Sections 834, 835, 836, 887, 889, 889.1, 839.5, 840 and 843)

A. Names and addresses of the applicant's officers.

B. The street number, city and state of applicant's home office (which shall be the state of incorporation, unless there is a separate executive office, in which event both shall be listed); also the mailing address, if different from the home or executive office address.

C. An itemized account of applicant's financial condition, including the amount and character of its assets and liabilities. Admitted insurers may refer to attached current financial statement or statements already on file with the Commissioner and incorporate them by reference. Nonadmitted insurance companies shall furnish their latest annual statements in the form prescribed by the N.A.I.C. Blanks Committee, both copies signed and verified by appropriate officers of the company, one copy of which shall be certified by applicant's home state insurance Commissioner as being a true copy of the same on file in his office. If such statement is not available (as in the case of underwritten title companies, attorneys–in–fact of reciprocal insurers, exclusive managers of domestic insurers–elsewhere defined as "insurers" but not as "insurance companies"), furnish independent audit or other recent financial statement. A copy of a recent Registration Statement, Form S–1, filed with and acceptable to the Securities and Exchange Commission, will normally suffice in lieu of an annual statement unless the condition of applicant's finances or its book of business is unsatisfactory or cannot be accurately ascertained from such Registration Statement, in which event the Commissioner will insist upon a certified annual or more recent statement in the form of the annual statement prescribed by the N.A.I.C. Blanks Committee.

D. A detailed statement of the plan upon which applicant is transacting or proposes to transact business. Admitted applicants may refer to and incorporate by reference their latest report of examination and financial statement filed with the Commissioner. Any substantial new departure in plan of business or method of operation shall be fully alleged. Nonadmitted insurance companies shall attach reports of most recent examination, one copy of which shall be certified by applicant's home state Commissioner as a true copy of the same on file in his office. Nonadmitted insurers in most cases may attach as an exhibit to their application and incorporate a copy of a recent Registration Statement, Form S–1, filed with and acceptable to the Securities and Exchange Commission in lieu of a certified Report of Examination, if such a Registration Statement is available.

E. A voided specimen of any certificate for shares of stock, subscription warrant, option, contribution certificate, or other security which applicant proposes to issue.

F. A copy of any underwriting agreement, agreement among underwriters, selected dealer agreement, or any other contract applicant has made or proposes to make concerning the issue or providing for sale or disposition of the shares. Press proofs are acceptable for initial filing, but may be required to be supplemented by reprints completed as to dates, commissions, expenses, etc. (but not necessarily as to price), before a permit is issued. If final prints cannot be supplied before issuance of the permit on account of the fact that price and commissions are to be set immediately prior to the proposed offering, the Commissioner may act on the basis of such information supplied orally to be subsequently confirmed in writing by telegram or letter. When, in the Commissioner's judgment a copy of the papers as finally completed is essential to establish compliance with the law or to complete the record, the permit may

require mailing to the Commissioner of a reproduction of the executed document for filing. In that event such copy shall be certified by an officer of applicant, attested by its corporate seal, to be a true copy of the document relied on by the parties thereto.

G. A copy of any prospectus or advertisement or other description of the securities sought to be issued, which applicant will circulate or publish. File preliminary prospectus and Registration Statement, Form S–1 (if any) with application and supplement by all amendments thereto. The Commissioner reserves the right to require the (final) prospectus to be filed before his (definitive) permit is issued. However, in the case of nationwide issues where time is an important factor, the permit can be issued before receipt of the (final) prospectus if the Commissioner is satisfied that it will be unchanged from the latest approved preliminary prospectus already on file except for changes required by S.E.C. rules. In such event, the permit will require that two copies of the (final) prospectus be mailed to the Commissioner for filing simultaneously with mailing to the offerees. Applications for organizational permits are required to include a prospectus or offering circular if there is to be a public sale of securities.

H. A copy of any letter to stockholders, offering letter, letter of solicitation, proxy, proxy statement, letter of extension or other circular concerning the securities to be issued. Final prints shall be filed before permit is issued, if at all possible. Otherwise, the permit will require mailing of duplicate final prints in the same form and text as the latest version on file to the Commissioner for filing simultaneously with mailing to the offerees. If a copy bearing the "Approved" stamp is desired for applicant's records, applicant shall mail the Commissioner three copies.

I. Applicant's articles of incorporation. Admitted insurance companies with articles as amended to date already on file in the Commissioner's office where the application for permit is filed may refer to and incorporate same by reference. Nonadmitted applicants must file their articles of incorporation, or comparable documents, as currently amended. One copy shall bear the original certificate of the official governmental custodian of the original thereof to the effect that it is a true copy of the same on file in his office. If a former application filed in the same office within two years prior to the instant application contained articles of incorporation so authenticated, they may be identified by specific reference to the file by entitlement, file number and date of filing, and may be incorporated by reference when so identified. Any amendment made since such prior filing, unless already officially filed with the Commissioner, shall be attached to or accompany the application. It shall be similarly authenticated. This portion of the application shall positively allege that the articles attached by exhibit, or incorporated by specific reference, or both, are applicant's articles of incorporation as currently amended to date of the application. (Sec. 836)

J. By–laws or comparable governing rules shall be attached or incorporated by reference. This exhibit may be cared for under similar circumstances in the same manner as required of articles of incorporation by the preceding paragraph hereof. Both copies shall be authenticated by the certificate of a corporate Secretary or Assistant Secretary attested by the company seal to the effect that they are true copies of the company by–laws currently in force.

K. A copy of the pertinent minutes of any proceeding of applicant's directors, stockholders, or members relating to or affecting the current issue of securities or transaction sought to be authorized. They are to be certified over the original signature of a Secretary or Assistant Secretary, attested by the corporate seal, to be true copies of true excerpts. (Section 836)

L. Foreign applicants (not organized under the laws of this state must file, either with their application or separately, before a permit can be granted, an original certificate of their domiciliary insurance commissioner or other proper officer of the jurisdiction in which they are organized certifying that applicant is on the date of the certificate duly authorized to transact business in its domiciliary state. Such certificate will not be acceptable if issued more than 30 days prior to the date on which such application is filed with this Department. (Section 837(a))

M. Section 837(b) requires that nonadmitted applicants (not holding a California Certificate of Authority) must file a stipulation or agreement for service of process. As a practical matter, admitted insurance companies who have on file with the Insurance Commissioner a current appointment of agent for service of process, as required by Insurance Code Sections 1600–1603 and the stipulation required by section 1604 ibid., as those sections provided on or after September 30, 1963, need not file the stipulation described in section 837(b); otherwise, insurers shall make and file the stipulation required by said section 837(b). Forms may be obtained from the Department.

HISTORY

1. Editorial correction of subsection M. (Register 91, No. 15).

§ 2603.13. Other Allegations Required in All Applications.

Unless otherwise provided by these regulations or authorized by statute, every application for an insurer securities permit shall allege under oath or lawful verification as to the truth thereof the following information, either in the body of the application or by exhibits referred to and incorporated therein so as to be included within the scope of the oath or other verification:

A. The number, class or kind, par value (or, in case of noninsuring "insurers" with no par stock, the stated value) and amount of securities applicant proposes to sell.

B. The sale price or other consideration to be paid therefor per share and in gross for the total number of shares or other securities sought to be authorized by the permit applied for.

C. The selling commission and any other compensation, including but not limited to stock options, to be paid or allowed, directly or indirectly, and to whom.

D. Applicant's best estimate of the total expenses to be incurred on account of such sale.

E. The purpose of the sale and issue, exchange or other action for which a permit is sought, what is expected to be accomplished thereby and the anticipated effect thereof upon applicant's financial position, including capital paid up and unassigned surplus in the case of insurance companies, and capital, or capital and surplus in the case of underwritten title companies and other noninsuring "insurers." Detailed pro forma financial statements are not ordinarily required, but may be, particularly in the case of insurance companies.

F. In the case of an application for any kind of stock option plan, a copy of the plan with evidence of its lawful adoption by applicant's board of directors and stockholders—subject to any lawfully required approval of appropriate securities regulatory authorities—, and a copy of each form of security, option or contract for a security proposed to be issued in connection therewith.

G. In case of an application for a negotiating permit, a description of the matters desired to be negotiated.

H. Any other, different, additional facts, data or information which the Commissioner may reasonably request as needed for him to make and substantiate findings, affirmative or negative, required by law to be made by him before a permit may issue, or authorized to be made in respect to the transaction for some part of which the permit applied for is needed. (Sections 839, 839.1, 839.5, 715, 840, 842, 843)

§ 2603.14. Financial Data—In General.

A. Applications filed by insurance companies with capital stock shall set forth both the number and par value of shares outstanding and the amount of capital paid up as of the date of the application. Both stock and mutual (including inter–insurance exchange) applicants shall state their total assets, total liabilities exclusive of capital, unassigned surplus and surplus as regards policyholders as of the most recent financial reporting date. If there have been significant changes between that date and the date of filing the application, the application shall include applicant's best estimate of the amount of unassigned surplus as of the date of such application.

B. Applications filed by insurers other than insurance companies (i.e. by non–insuring "insurers") shall show the most recent balance sheet and

operating statement of applicant that are available. If such papers are stale or unreliable, the Commissioner may require current balance sheets and current operation statements.

C. In the case of any application lawfully filed (whether described in paragraph A or paragraph B above), the Commissioner, after examining it and the other papers and documents filed with it, may if he deems it advisable, cause a detailed examination, audit and investigation to be made of applicant and its affairs (Section 838). Such examination, audit or investigation shall be at the expense of applicant (Section 859(d)).

§ 2603.15. Company Information—In General.

The size, age and financial condition of insurers vary so greatly, and the kinds of permits applied for are so different, it is impracticable to prescribe regulations covering all situations. However, every application should allege enough facts to show the nature and extent of applicant's business, its present financial condition, whether a sale of the company, or merger, consolidation, reorganization, change of management or control or other major management or financial change is planned or pending, and whether any large acquisition, sale, or cession is contemplated in the near future. (Sects. 839, 843).

§ 2603.16. Exhibits.

Exhibits shall be consecutively numbered or lettered. Plainly legible numbering or lettering shall be placed consistently either in the bottom center or at the lower right–hand corner of the face or first page of each exhibit. If there are no more than three exhibits they need not be separately tabbed. If there are four or more exhibits or, in any event, if the application and exhibits exceed fifteen pages in length, exhibits shall be labeled by index tabs affixed either to the right–hand margins or at the bottom of the face pages in a consistent fashion so that the tabs will be visible when the application is punched and affixed in a manila folder with an Acco fastener.

Exhibits shall normally be arranged and attached to the typewritten application so they can be opened and read without taking the file apart. Bulky or cumbersome exhibits, such as quarterly or annual financial statements, registration statements (with S.E.C.), underwriters' agreements and ratebooks and other similar items, not easily capable of being fastened in a manila folder with the typewritten application may remain separate.

§ 2603.17. Findings Required by Statute.

Every application for a securities permit must show either in the body of the application or by exhibits sufficient facts to enable the Commissioner to make the findings required by Insurance Code Section 839, to wit:

A. That the proposed plan of business of the applicant and the proposed issuance of securities are fair, just and equitable;

B. That applicant intends fairly and honestly to transact its business; and

C. That the securities applicant proposes to issue and the methods to be used by it in issuing or disposing of them are such as, in his opinion, will not work a fraud upon the purchasers of the securities or upon policyholders or other security holders of applicant.

§ 2603.18. Optional Findings, Anti–Trust.

"(a) In any case where a domestic insurer is directly affected by the total transaction for some part of which the permit applied for is needed, and the Commissioner in his discretion determines that reasonable grounds exist for contentions that such total transaction or any part thereof:

(1) Is a combination of capital, skill, or acts to create or carry out restrictions on or to prevent competition in the insurance business; or

(2) Is a combination (in the form of a trust or otherwise) in restraint of the insurance business; or

(3) Is an attempt to monopolize the insurance business; or

(4) Is a conspiracy to create any of the foregoing; or

(5) That such total transaction, or any part thereof, if consummated will create or result in any of the foregoing or will substantially lessen competition in the insurance business;—

Then, in such event, the Insurance Commissioner may make findings with respect to whether such total transaction, or any part thereof, would or would not do or be any of the foregoing.

(b) In the event the Insurance Commissioner makes affirmative findings as provided in subdivision (a) of this section, he may deny the permit applied for." (Section 839.1)

§ 2603.19. Filing Fees.

The filing fees required by Insurance Code Sections 857 to 859, inclusive, shall be paid not later than concurrently with the filing of the application. Applications transmitted by mail for filing should be accompanied by a check made payable to the order of the State of California Insurance Commissioner for the full amount of the filing fee. The Commissioner reserves the right to reject any application not so accompanied by the correct filing fee.

Such fees are for filing and are not refundable in the event a permit is refused. The statute should always be consulted in case of doubt as to the amount. A summary of the filing fee requirements with illustrative computations follows (Section 857):

Original application or supplemental application for permit to issue securities (except application for permit to issue securities evidencing any change in the rights, preferences, privileges or restrictions on outstanding securities): _____$75.00 plus the sum of the following computed on the aggregate value of the securities to be issued:—

20/100 of 1% of any excess over $1,000 and not exceeding $50,000 ($98) _____
10/100 of 1% of any excess over $50,000 and not exceeding $100,000 ($50) _____
5/100 of 1% of any excess over $100,000 and not exceeding $500,000 ($200)
2/100 of 1% of any excess over $500,000 and not exceeding $5,000,000 ($900) _____
1/100 of 1% of any excess over $5,000,000 and not exceeding $10,000,000 ($500) _____
1/500 of 1% of any excess over $10,000,000 _____

Application for permit to issue securities evidencing any change in the rights, preferences, privileges, or restrictions on outstanding securities (Section 857(b)):——————————————$75.00.

Application for permit to issue rights, warrants, etc., except where the market price is higher than the selling price: ——————$50.00

Application to amend existing permit (Section 859(a):———$37.50

Application for preorganization, subscription or negotiating permit (Section 859(a)):——————————————$37.50

The following paragraphs summarize applicable Insurance Code sections governing the determination of value of the securities involved (Section 858):

A. Take par or face value, unless the consideration alleged in the application or as found by Commissioner is in excess thereof, or unless the securities when issued will have a value as determined by the Commissioner in excess of their par or face value,—in either of which events,take the larger figure. (Section 858(a))

B. If the securities have no nominal or par value and if issuance is otherwise lawful (Section 690), the value shall be taken as the proposed sale price, or the value alleged in the application, or the actual value of the consideration (if other than money) as determined by the Commissioner, or the value of the security when issued, whichever is greatest. (Section 858(b)) For securities reported on stock exchange, take value based on stock exchange price. For securities traded substantially over–the–counter, take average of recent daily mean between bid and asked. (Section 843)

C. In calculating the fee on stock rights, subscription warrants, stock options, etc., compute value at difference between the selling price of the securities represented thereby and market value of such securities on day

before application was filed, provided the market price is higher than the selling price; otherwise, the rights, warrants, options, etc., shall be deemed to have no value and the fee for filing such application shall be $50.00. (Sections 858(c), 843)

D. In case of an application to issue securities containing conversion rights, compute value of securities to be issued at twice the amount of the consideration to be received therefor. (Section 858(d))

E. In case of a share dividend or share split, value of the securities to be issued shall be the amount of the surplus proposed to be transferred to paid–in capital. (Section 858(e))

NOTE: Authority cited: Section 857, Insurance Code. Reference: Sections 820–860, Insurance Code.

HISTORY

1. Amendment filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2603.20. Grounds for Denial.

If an application that otherwise complies with the law and these regulations is insufficient to enable the Commissioner to make the findings required by Insurance Code Section 839 and, if in his discretion he so determines and requires, the findings (affirmative or negative) authorized by Section 839.1 ibid., he will notify applicant in writing of his objections. If they are not cured by supplement or amendment within a reasonable time, he will deny the application and notify applicant in writing of his decision. (Sections 839, 839.1)

§ 2603.21. Denial for Laches.

Applications will not be allowed to pend indefinitely or for an unreasonable length of time. An application will also be subject to denial if it reasonably appears that applicant is not actively correcting reported defects and remedying reported deficiencies in good faith, or that it will be impossible for applicant within a reasonable time to comply with the Commissioner's appropriate lawful requirements. (Section 843)

Article 4. Preorganization, Subscription and Negotiating Permits

§ 2604.01. Prepermit Activities.

Prior to issuance of an appropriate permit promoters may not lawfully do anything in this state which produces an agreement, express or implied, to buy an identified security. *People* vs. *Jacques* (1955) 138 Cal. App. 2d 823, 291 Pac. 2d. 124; *Ogier* vs. *Pacific Oil and Gas Development Corporation* (1955) 138 Cal. App. 2d 775, 779, 288 Pac. 2d 101. But a business conversation preliminary to any fixed plan is not prohibited. *B. C. Turf and Country Club* vs. *Daugherty* (1949), 94 Cal. App. 2d 320, 210 Pac. 2d 760. The promoters themselves and their legal counsel are responsible for determining how far they may go in the talking stage without a permit. Refer to Sections 2602.01 to and including 2602.08, supra, and the statutes and decisions cited; also to any subsequent controlling decisions.

§ 2604.02. Applications for Preorganization Permits.

NOTE: Applicants most commonly apply directly for a definitive permit without any intervening formal steps or preliminary permits. The sections herein provided relative to preorganization and subscription permits are only designed to accommodate the limited situations described therein. Definitive permits regularly authorize the taking of subscriptions.

A. Except as may otherwise be specifically provided by law, when individuals in the course of organizing a proposed insurer expect to engage in solicitation or obtain commitments which cannot lawfully be done without an appropriate permit, but will not take subscriptions for the purchase of securities, they should apply for a preorganization permit.

B. The fee for filing an application for a preorganization permit is $37.50 (Section 859(a)). Formal requirements, such as verification, number of copies, filing office, etc., are governed by Article 3 of these regulations.

C. Such an application shall set forth:

1. The names and addresses of the proposed organizers. It shall also incorporate by reference biographical affidavits on a form prescribed and furnished by the Commissioner, one of which shall be completed and sworn to by each organizer. The form of biographical affidavit is found in Section 2613.07, infra. (Sections 704.5, 717, 718, 843)

2. The names and addresses of all persons then known who are expected to be associated as officers, directors, or as key managerial personnel.

3. The kind of insurer to be organized, the nature of the business to be done and where.

4. The reason why such an insurer is proposed to be organized; any particular advantage it would enjoy; why, in the opinion of the promoters, it should succeed.

5. The capital structure of the proposed insurer, the par value (if any; see Section 690 for insurance companies) and the selling price of its shares, the number of shares proposed to be sold, by whom, where and how they are proposed to be sold and the commission to be paid or allowed thereon, the amounts of capital paid up and of unassigned surplus (if applicable) with which it is proposed to start business; also, the estimated expenses of organization and promotion.

6. The names and qualifications or, if it is not possible to identify them, a description by class of the persons to be solicited, the purpose of such solicitation, and the proposed dates of commencement and conclusion thereof.

D. Such permits may be issued without findings being made pursuant to Sections 839 and 839.1 of the Insurance Code, and will not authorize the taking of subscriptions for issuance or sale of any security, or the collection of any consideration for purchase of securities. (Sections 827.7, 843)

NOTE: Authority cited: Section 843, Insurance Code. Reference: Section 859(a), Insurance Code.

HISTORY

1. Amendment of subsection B filed 5–6–77 as procedural and organizational; effective upon filing (Register 77, No. 19).

§ 2604.03. Application for Subscription Permits.

A. Applications for a permit of this nature presuppose a corporate applicant with or without assets but with officers and directors, a well-defined plan of operation and an application with substantially all of the exhibits required in the case of an application for a permit authorizing a newly organized insurer to sell its first issue of shares. (See Section 2605.01, infra, on "Applications for Organizational Permits.") Such a permit will authorize the taking of conditional subscriptions for the purchase of a particular security at a stated price, but will not authorize the collection of stock purchase money. All subscriptions shall recite substantially the conditions set forth in the specimen form set forth in Section 2613.05, infra, except that the time limits may be reasonably varied to suit applicant's plans. It is possible to issue such a permit prior to the making of findings required by Insurance Code Section 839. (Section 827.7, 843) However, in the event a permit is issued on the latter basis without such findings, it may under the circumstances hereinafter specified require that each subscriber be afforded an opportunity, within a reasonable time after receipt by him of a copy of the Commissioner's definitive permit and of the prospectus as finally approved by that permit, to disaffirm and cancel his subscription. The circumstances referred to in the preceding sentence are these:—where in the Commissioner's judgment there has been a change between the dates of issuance of the subscription permit and of the definitive permit in the proposed venture which would render it unfair, unjust or inequitable not to allow the subscriber to withdraw; such changes include, but are not limited to, a substantial change in applicant's plan of financing or plan of operation, or among the organizers, promoters, original officers, directors or proposed key managerial personnel.

The filing fee is $25 payable at the time of filing the application. (Section 859(a))

B. Except as otherwise authorized by statute and these regulations, applications for subscription permits shall:

1. Comply with Sections 2603.01 to and including 2603.11; paragraphs A., B., D., G., H., I., and K., and if applicable L. and M. of Section 2603.12; paragraphs A. through E. of Section 2603.13 and Sec. 2603.16.

2. Attach the form of subscription (see Sec. 2613.05 for sample) and any other proposed contract, and all advertising or solicitation material proposed to be used. Such materials may not be used unless a permit is issued and their use has been approved by the Commissioner in writing.

3. State the desired commencement and termination dates of the subscription effort.

§ 2604.04. Applications for Negotiating Permits.

NOTE: The presence in these regulations of this and the following section in this article does not mean that a negotiating permit is a necessary precedent to a definitive permit. A definitive permit may always and quite often does authorize negotiations. Where applicant is confident its "negotiations" will succeed, it customarily skips the negotiating permit stage and applies directly for a definitive permit. These sections represent the present practice and, in accordance with the Code, only provide for an intermediate step where applicant is not ready to proceed on the ultimate definitive permit basis.

Except as may otherwise be provided by law or these regulations, under the appropriate circumstances applications for negotiating permits may properly be filed by authorized insurers, admitted or nonadmitted. If an application seeks authorization to solicit or "negotiate" for acceptance of a proposal whose terms, conditions, value and consideration are already fixed and no substantial part of which is to be arrived at through bargaining, then such application must make the showing needed upon which to base findings required by Insurance Code Section 839 and, if the Commissioner requires, authorized by Section 839.1 ibid. Otherwise, if the application shows that the terms and conditions of the proposal sought to be negotiated, or the value or consideration to be paid are still to be agreed upon through genuine bargaining, then such application need not show the basis for findings under said Sections 839 and 839.1. In the latter event a permit issued in response to such an application will make no findings under said sections and will authorize negotiations only.

§ 2604.05. Application Not to Be Ambiguous.

An application of the type described in the sections immediately preceding and following this section shall be for a negotiating permit or for a definitive permit but not for both unless the appropriate filing fee for a definitive permit is paid. If it requests two permits, a negotiating and a definitive permit, then the appropriate filing fees for both shall be paid when the application is filed. If it cannot be told from the application itself what kind of a permit is wanted, no permit will issue. The Commissioner will endeavor to reject ambiguous applications in advance of filing. (Section 843)

§ 2604.06. When Negotiating Permits Are Appropriate.

Negotiating permits are appropriate under the following circumstances:

A. Applicant desires to approach the governing body of another entity concerning a proposal which, if duly adopted by the parties, will require the commissioner's (definitive) permit in order lawfully to effectuate the same.

B. Applicant has in another state reached an agreement or tentative agreement with the governing body of another entity as to the terms of such a proposal and desires to present the same to California stockholders by mail, or otherwise, for their votes thereon.

C. Applicant for any legitimate reason needs to negotiate concerning the terms and conditions of a proposal the consummation of which, if agreed upon, will require a definitive permit; or needs to submit a definitive proposal to a vote of stockholders or members preliminary to the action for which a definitive permit will be needed.

§ 2604.07. Regulations Governing Applications for Negotiating Permits.

Except where herein otherwise noted, applications for negotiating permits are governed by the same statutes and regulations as are other applications. Applications for negotiating permits shall comply with the applicable portions of the following sections hereof: 2603.01 to and including 2603.16. The application shall describe the matters to be negotiated and attach a copy of the plan of reorganization, agreement of merger, or other proposal, and copies of all solicitation material to be used in this state. The filing fee is $25.00. See Insurance Code Section 859. (Sections 827.7, 834, 835, 836, 837, 843)

Article 5. Organizational and Other Definitive Permits

§ 2605.01. Applications for Organizational Permits.

Applications by underwritten title companies, attorneys-in-fact of reciprocal insurers, and exclusive managers of domestic insurance companies for permits to sell their stock for initial capitalization purposes, are subject to and shall comply with the applicable portions of Articles 1 through 4, paragraphs B., C., E., G., and H., of this Section 2605.01, and paragraph B. of Section 2605.02. Similar applications by insurance companies (organizations organized to assume the risk of loss under contracts of insurance) in addition to complying with the last aforementioned sections and articles hereof, shall (Sections 717, 718, 721, 839, 843):

A. Comply with Article 3, except Sections 2603.14 and 2603.15, of these regulations and with the additional requirements set forth in this section.

B. Attach as an exhibit and incorporate by reference on a form provided by the Commissioner, a biographical affidavit of every officer, director, trustee, each proposed principal supervising or managerial personnel, and of each known proposed investor who is expected to purchase or hold or control for himself or otherwise, directly or indirectly, 10% or more of applicant's stock when it is sold and issued. Such affidavit shall be completed by the individual concerned and, if executed in this state, shall be either certified to under penalty of perjury or sworn to before an officer duly authorized to administer oaths; and if executed in any other place than the State of California, shall be duly sworn to under oath according to the law of the place where the affidavit is made. The form and text of such affidavit shall be as set forth in Section 2613.07, infra. (Sections 704.5, 717, 718, 843) It may be filed in a singular copy only.

C. Allege or attach as an exhibit incorporated by reference a plan of operation explaining fully at least the following to the extent that these items are appropriate to the nature of the applicant.

NOTE: All items are appropriate to an organization expecting to transact "insurance" as the same is defined by Insurance Code Section 22):

1. Kind of business the company will transact; if "insurance" as defined by Insurance Code Section 22, name the classes as they are defined by Insurance Code Section 101–120; otherwise, describe it. Specify where and with what facilities business will be transacted and the estimated premium volume of such transactions by month or year.

2. Whether company will operate on the American Agency System or as direct writers.

3. Where and how it will recruit its agents or other producers. How and by whom they will be trained.

4. Commission rates or salaries to be paid. Attach sample contract forms and commission schedule, including those for general agents.

5. Where and how business will be developed.

6. Sales techniques to be used.

7. Advertising methods to be employed.

8. Whether applicant will control agents' advertising and sales methods and, if so, how.

9. How and by whom claims will be processed and losses adjusted and paid; the relationship of such adjusters to company.

10. How claims adjusting personnel will be compensated.

11. If applicable, whether applicant will comply with Insurance Code Sections 815 and/or 816, as appropriate.

12. How and by whom applications will be underwritten.

13. Initial salaries proposed to be paid.

14. How and by whom the company's investments will be managed and, if by other than a company officer, for what compensation.

15. If applicant expects to transact life or disability insurance, whether it will pay or contract to pay directly or indirectly to any officer, director, trustee, medical director, actuary or investment committeeman any commission or compensation contingent on life or disability business written, renewed or paid for and, if so, at what rate or rates and under what circumstances.

16. What procedure, if any, company will have to ascertain whether its officers and directors occupy positions in other businesses or have other financial interests such that applicant's business or investment transactions or conduct of its business will directly or indirectly affect them or their other financial interest, and vice versa. (Sections 843, 1101 and Ops. Cal. Atty. Gen. No. 64/230, Sept. 24, 1965.) (Sections 839, 843 and Corporations Code Sec. 820 as to noninsuring insurers.)

D. Attach as an exhibit and incorporate by reference its principal policy or policies (usually not more than two) to be sold and the rates therefor. Typewritten forms are acceptable for application purposes. Statutory forms may be identified by reference to the statute. Standard forms and Bureau forms may be identified by form number and printed copies attached.

In the case of nonstandard policies, there shall be included an actuarial demonstration of the financial soundness of such policy or policies and rates.

The requirements of this paragraph D are customarily waived as to other than life and disability applicants if they can otherwise demonstrate the financial soundness of their policies and rates.

E. Attach as an exhibit and incorporate by reference a financial projection, based on reasonable and practicable assumptions of every applicable factor, including volume and kind of business to be produced, premiums to be collected and disbursements to be made, all year by year, showing separately: (1) all elements of income, (2) all elements of disbursement and reserves, and (3) unassigned surplus at the end of each year. Such projection shall cover a period of years from inception to and including a year when it shows applicant is definitely producing a net gain from operations after dividends to policyholders and excluding capital gains and losses. (Secs. 839, 843)

F. Actuarial computations and estimates are not acceptable unless signed and certified to by a qualified actuary.

G. Attach as an exhibit and incorporate by reference a detailed estimate of all expenses incurred or to be incurred, beginning with the cost of incorporation and extending to and including the procuring of a Certificate of Authority. (Secs. 839.5, 715) Limit to expenses of organization and stock selling in case of noninsuring insurers.

H. Attach as an exhibit and incorporate by reference applicant's proposed reinsurance contracts. (Insurance contracts in case of underwritten title companies.) If the text of these is not available, attach written commitments and typical contract; otherwise, attach analysis of bids for reinsurance and statement of company's choice and include terms. (Sections 717, 839, 843)

§ 2605.02. Amount of Proof Required.

A. In the case of domestic applicants being organized for the purpose of assuming the risk of loss under contracts of insurance, the quantum of proof customarily needed pursuant to Insurance Code Section 839 must be sufficient to satisfy the commissioner of at least the following with respect to applicant:

1. That it has a practicable, workable organization and plan of operation with honest, experienced, competent persons in charge;

2. That it has actuarial sound policies to sell at merchantable rates;

3. That it will employ lawful sales methods;

4. That its underwriting and rating will be lawful and practicable;

5. That its reinsurance arrangements are provident and lawful;

6. That it has access to or can develop sufficient premium income to survive;

7. That it will promptly and fairly adjust claims by its policyholders and will fully pay such claims in accordance with law and the terms of the policies;

8. That its investments will be lawfully made and skillfully managed;

9. That its operations and business ought to produce a fair profit within a reasonable period; and

10. That its plan of financing and stock selling will produce enough funds so that applicant can and will maintain statutory financial requirements and avoid a hazardous condition until earned premium income plus investment income exceeds all expenditures. (Sections 717, 839, 843)

B. In the case of applicants described in paragraph C. of Section 2601.02 hereof other than those mentioned in paragraph A. of this section, the quantum or proof required shall be such as by a preponderance of evidence will enable the Commissioner to make all findings necessary or appropriate under the circumstances.

C. The quantum of proof required of foreign or alien applicants shall in no event be less than that required of a similar domestic applicant applying for a similar permit. (California Constitution, Article XII, Section 15.) The proceeds of California stock sales by such applications shall be subject to the impound requirements of these regulations the same as if they were domestic applicants. Cf. Section 2606.01, infra.

§ 2605.03. Special Provisions for Certain Nonorganizational Permits.

A. Already organized and licensed applicants, domestic or foreign, whose operations and management have not consistently proven financially successful will be required to substantiate their applications with such of the items listed in paragraphs (Omit D. and F. for noninsuring "insurers.") B., C., D., D., E., F., G., and H. of Section 2605.01 above as are appropriate and necessary to induce the findings needed pursuant to Insurance Code Section 839. Such applicants are commonly requested to furnish the following additional verified information in their applications:

1. When applicant was last examined by its own state regulator authority or by N.A.I.C. Zone Examiners.

2. Whether applicant is presently engaged in a controversy with any state or federal regulatory agency. (Application for admission is not deemed a "controversy.")

3. Whether applicant has within five (5) calendar years last preceding the filing of the instant application been: (a) denied a certificate of authority or a license to transact insurance or has withdrawn an application therefor in any jurisdiction; (b) denied authorization to sell its securities; or (c) ordered to cease and desist from selling its securities in any jurisdiction. If the answer to any of the questions in this paragraph is affirmative, state the circumstances.

4. A list of pending lawsuits including those arising under its policies of insurance (other than liability, surety, workmen's compensation policies and subrogation suits) against the applicant, together with an estimate of the probable outcome and liability under each. (Sections 839, 843)

B. Applications by licensed but relatively new companies for permits to sell securities for the purpose of raising supplemental capital or surplus to meet statutory requirements, or additional funds to finance current or future expenses, ordinarily need to devote special attention to the selling price of shares, condition of applicant's business and affairs, and results shown by the expenditure of surplus to date. The Commissioner has the power to review price. (Sections 839, 840)

§ 2605.04. Applications by Noninsuring Organizations.

Applications for permits by underwritten title companies, attorneys-in-fact for reciprocal or interinsurance exchanges, or exclusive managers of domestic insurers, or by any organization formed for the purpose of acting as any of the foregoing, shall be subject to and shall comply with

Article 3 of these regulations, supra. They shall also be required to furnish such additional data, information and documents as the Commissioner may reasonably deem necessary in order to make possible affirmative or negative findings on the matters essential to issuance of the permit applied for.

§ 2605.05. Applications by Established Insurers.

A. In the case of insurance company applicants who have the following qualifications, their applications and exhibits may be simplified to the extent hereinafter permitted. The qualifications for such an applicant are that (Section 843):

1. It has, prior to filing the application, made a registration filing with the Securities and Exchange Commission for a public offering of securities and a copy of its latest complete filing is attached to and incorporated by reference in the application.

2. It (or a predecessor by merger, sale and purchase transformation or other reorganization, provided that at least 50% of the gross business in force and at least 50% of the management—including total number of officers and directors—of applicant are in such case each comprised in excess of 50% of the business and management of the merged, purchased, transformed or reorganized predecessor) has been lawfully engaged in the insurance business for at least five years and currently is admitted to transact insurance in at least five states;

3. It currently has admitted assets of at least five million ($5,000,000) dollars; and

4. It has, prior to filing the application, obtained a written permit or consent to issue such securities from the authority in its domiciliary state having jurisdiction over issuance of its securities, and the statutory standards for obtaining such a permit or consent are comparable to the like standards of this state. The statutes of another state are not deemed "comparable" within the meaning of this subparagraph 4 unless they include requirements substantially like Insurance Code Section 839 (the "fair, just and equitable" section). See Section 2603.17, supra. (Section 843)

B. Applications for permits by insurers which allege and prove the qualifications set forth in paragraph A of this section are subject to and shall comply with Article 3 of these rules, except paragraphs D., I., J. and K. of Section 2603.12.

C. Any foreign applicant relying on this section shall allege that the statutes of its domiciliary state provide standards for obtaining such prior permit or consent that are comparable to the like standards of this state, and as proof thereof shall attach a copy of the statute and relevant regulations of its domiciliary state to its application.

§ 2605.06. Applications by Large Established Insurers.

A. In the case of those insurers who have any four of the following five qualifications, their applications may be simplified to the extent hereinafter permitted. Insofar as in the Commissioner's discretion may prove feasible, permits issued to such insurers will be abbreviated or simplified. The qualifications for such an insurer are that:

1. It (or a predecessor by merger, consolidation, sale and purchase, transformation or other reorganization, provided that at least 50% of the gross business in force and at least 50% of the management—counting the total number of officers and directors—of applicant are in such case each comprised in excess of 50% of the business and management of the merged, purchased, transformed or reorganized predecessor) has been continuously engaged in the insurance business for not less than 40 years.

2. It is, according to its latest annual statement on file with the Commissioner, admitted to do business in not less than 40 states of the United States of America.

3. It has, according to its latest annual statement on file with the Commissioner, a surplus as regards policyholders of not less than $50,000,000.

4. As part of the same transaction for which a permit is sought from the Commissioner, it has on file a current Registration Statement with the Securities and Exchange Commission for a public offering of securities; and applicant has made a registration of its shares effective with the Securities and Exchange Commission for such purpose on at least two prior occasions within the ten calendar years last preceding the current application to the Commissioner.

5. Trading in and market prices of its stock are regularly listed in at least one newspaper with nationwide circulation.

B. The application of any insurer described in paragraph A, above, may be abbreviated to the following extent:

1. It shall be subject to and comply with Sections 2603.01 through 2603.11, and 2603.16 through 2603.21 of Article 3, ante.

2. In addition, it shall allege: class or kind, par value (or face value), and number or amount of its securities applicant proposed to offer and sell to or exchange with California residents; the price per share and the expected gross California proceeds of such sale or other gross consideration expected therefor.

3. It shall refer to and incorporate the following exhibits which shall be attached to the application: (a) a voided specimen of the certificate or paper representing each class or kind of security proposed to be issued; (b) a copy of its Registration Statement to become currently effective; and (c) the written communications, solicitations, or advertising sought to be approved.

4. If applicant is a foreign corporation, admitted or nonadmitted, it must file the certificate required by Insurance Code Section 837(a). See Sec. 2603.12, paragraph L., ante. If it is a foreign nonadmitted corporation, it must also comply with paragraph M. of Section 2603.12, ante.

5. The application shall be verified positively; a "verification" solely on information and belief is not acceptable. Section 2603.10, ante, contains forms of verification, q.v.

6. The application and all exhibits required to be filed (or incorporated by reference) shall be filed in duplicate by applicants filing in Los Angeles and in singular copy by applicants filing in San Francisco.

Article 6. Impounding of Stock Sale Proceeds

§ 2606.01. When Required.

Permits issued to domestic applicants prior to a certificate of authority will normally require 100% of all stock sale proceeds to be impounded until release upon written order of the Commissioner. The same shall be required of the proceeds of stock sales in California by foreign applicants under similar circumstances. If applicant does not qualify for a certificate of authority within a reasonable time, subscription moneys will be returned in full to the subscribers without deduction of expenses. Extensions beyond such time will not be granted without the consent of all subscribers. The form of subscription agreement shall recite all of the foregoing. (A composite example of a subscription agreement is found in Section 2613.06, infra.)

A "reasonable time" as used in this section is ordinarily considered one year from the date the definitive permit is issued.

Impounding of funds may be dispensed with in cases of closed permits where applicant can demonstrate to the Commissioner's satisfaction that the protection of an impound to guarantee full return of stock purchase moneys in event no certificate of authority is granted is unnecessary. (Section 843)

§ 2606.02. Impound Agent.

Applications for permits which will entail impoundment of stock sale proceeds shall name a duly authorized federal or state bank within the state which has consented to act as impound agent. An originally signed letter of consent by the bank shall be attached to the application. (Section 843)

§ 2606.03. Certificate of No Lien.

Before an order is made releasing stock sales proceeds from impoundment, written assurance in letter form will be requested from the bank serving as impound agent that it has no lien, general, special, bankers, or

otherwise, against said funds or any thereof, and knows of no claims asserted against funds or any thereof. (Section 843)

Article 7. Promoters

§ 2607.01. Promotional Stock Not Allowed.

Various statutory provisions relating to paid–in capital, investments, insolvency and paid–up or unassigned surplus applicable to insurance companies (see especially Section 700.02(b)) render purely promotional securities difficult and impracticable. They were uniformally disapproved pursuant to Section 839. Fair, just, and equitable stock option plans for promoters, officers and employees are presently not regarded with disfavor.

§ 2607.02. Sales to Promoters.

In the event of a public offering, no securities will be authorized for promoters at less than the net public offering price.

§ 2607.03. Investment Required of Promoters.

Before any shares are offered to the public, except by conditional subscriptions without cash payment (Cf. Section 2613.05 infra) or are sold to the public, the promoters, organizers and all initial officers and directors as a group shall purchase and pay for in cash a substantial portion of the original issue on the same terms and conditions as share are offered to other investors. Ordinarily, such portion of the issue to be purchased by such persons as a group shall be not less than the sum of the following: 25% of the first million dollars and 15% of all amounts over one million dollars. Although such persons need not divide such purchase among themselves equally, ordinarily each shall make a substantial investment unless persuasive reasons why he cannot do so are shown. Absent good cause the size of such group shall ordinarily not exceed twenty in number.

§ 2607.04. Restriction of Sale of Promoters' Shares.

The persons investing pursuant to this article shall be required to execute an appropriate agreement with the company for the benefit of the company and all of its shareholders providing that the periods hereinafter specified from the date of completion of the original issue or granting of a Certificate of Authority, whichever is later, they and each of them will not sell, transfer, or encumber, except by operation of law, any shares acquired by them in satisfaction of the foregoing requirement or by exercise of promotional options without the written consent of the Commissioner. It will be permissible for each such person to dispose of the following amounts of the aggregate of his said shares after elapsation of the following indicated periods: 5% after one year; an additional 5% after two years; an additional 10% after three years; an additional 20% after four years and the remainder after five years. A restrictive legend prescribed by the permit shall be placed on each stock certificate representing such shares. A composite example of such a contract is found in Section 2613.08, infra.

§ 2607.05. Options to Promoters.

A. Issuance of options to promoters will not be authorized except in connection with an original issue and then only when it is satisfactorily demonstrated that the promoters have rendered a genuine service of value to the company for which they have not otherwise been fully compensated.

1. The issuance thereof will not ordinarily be regarded as fair, just and equitable unless:

(a) The total number of shares subject to such options will not exceed 10% of the number of shares initially sold and issued for cash.

(b) The exercise price stated in such options to be issued by other than a life insurer is not less than the net price at which shares are sold to the public investors at the time such options are granted, plus an increase of 5% thereof for each year thereafter elapsing during the life of such options.

(c) The exercise price stated in such options to be issued by a life insurer is not less than the net price at which shares are sold to public investors at the time such options are granted, plus an increase of 10% thereof for each year thereafter elapsing during the life of such options.

(d) The options are nontransferable except upon death of the optionee or by operation of law.

(e) The options by their terms are not exercisable more than five years after date of issue.

B. The intention to issue such options and the approximate extent thereof shall be fully disclosed in the prospectus.

C. Such options are a form of promotional expense and must be justified as such by a showing of the nature of the service rendered or other consideration justifying the grant of the options. The aggregate of all organizational expenses and promotional expenses, including the value of such options (as determined by the Board of Directors and subject to review by the Commissioner), shall not exceed 10% of the total amount actually paid for the insurer's capital stock. (Sections 839.5, 715)

§ 2607.06. Attorneys and Underwriters.

A. Stock options to attorneys at law for applicants are disfavored. (Section 839)

B. Stock options to underwriters are not permitted. (Section 839)

Article 8. Stock Purchase and Stock Option Plans

§ 2608.01. Officers, Directors and Employee Stock Option Plans.

Stock options of this nature are generally looked upon with favor where they conform to the following specifications:

A. They are provided for by a fair and reasonable plan to be fairly administered which has been submitted to and approved by the directors and stockholders. The Commissioner will insist on proof that a full and fair disclosure of outstanding options, the details of the plan and its intended operation has been made to applicant's stockholders, and that adoption thereof was in accordance with any applicable statutes.

B. The granting thereof bears a reasonable incentive relationship to the continued employment of the optionee.

C. They are for a stated number of shares, to be paid for in cash.

D. They are for 100% of the fair market value of the shares optioned as of the time they are granted, if issued pursuant to a plan which is by law subject to such requirement. If the stock is not widely traded, they are for a lawful price fixed by company's board of directors and concurred in by the Commissioner. If issued pursuant to an employees' stock purchase plan available to all of applicant's employees, they are for a price of not less than 85% of fair market value of the shares optioned as of the time they are granted. (Cf. Cal. Rev. & T.C. Sections 17534 and 17632)

E. They fully set forth employment qualifications, conditions for complete exercise of the option, conditions under which cessation of employment will terminate the option, the effect of death, resignation, etc.

F. They contain an anti–dilution or pro–ration clause in substance to the effect that the number of shares allocated to the Plan and the number of shares covered by each individual option, and the price per share, all shall be proportionately adjusted automatically for any increase or decrease in the number of issued and outstanding shares of the corporation accomplished without a corresponding increase or decrease in the corporation's paid–in capital.

G. Only the optionee (or a court appointed guardian) can exercise the option during the optionee's lifetime, and only his heirs, administrator or executor for a limited time after his death.

H. They provide in substance that the company will diligently endeavor to comply with all applicable securities laws before any such options are issued and before any shares will be issued pursuant to such options.

I. The term thereof is for not longer than five years.

J. The total number of shares set aside at any one time for such purpose or expected to be optioned for such purpose within the foreseeable future is not inequitably disparate to the number of shares issued and outstanding. Refer to Section 2608.04, infra. (Sects. 839, 843)

§ 2608.02. For Investment.

The Commissioner favors a requirement in such stock options plans and options issued thereunder that the optionee sign a stipulation when he exercises the option that he is purchasing for investment and not for resale (Sects. 839, 843)

§ 2608.03. Pro–Rata Exercise.

The Commissioner does not object to a requirement in such plans or options that the optionee shall exercise a pro–rata portion of his options each year or such portion shall automatically expire and thereafter be null and void. (Sects. 839, 843)

§ 2608.04. Overall Limitation on Options.

It is considered prima facie unfair, unjust and inequitable if the total number of shares subject at any one time to outstanding unexercised option rights of all types, including but not limited to promotional option, employee incentive options and life agents production options, exceeds or will exceed 20% of the number of the then issued and outstanding shares.

§ 2608.05. Procedure.

The Commissioner cannot and will not abdicate his authority and duty under Insurance Code Section 839. Hence, blanket permits for unlimited numbers of shares to be sold for unstated prices to undetermined people pursuant to exercise of options granted for undescribed reasons or under undisclosed circumstances will not be granted. The alternative procedures prescribed in this section will care for the most commonly encountered situations involving long term plans of this type, e.g., restricted or qualified stock options plans.

A. Applicant may apply for and obtain a negotiating permit for approval of its plan; and thereafter, from year to year as options are voted to be granted to employees, apply for and obtain a separate (definitive) permit for each year to issue options to the persons and for the number of shares specified in its board of directors' resolution and, upon due exercise thereof, to issue and sell shares accordingly. Such an application shall allege the exercise price to be stated in the options and shall by appropriate means show that it is fair, just and equitable.

B. An applicant having a long term plan, not desiring to follow the system outlined in Paragraph A of this Section, and which can satisfy other requirements, may proceed thusly:

1. It may apply for and secure a permit approving the plan for circularization and authorizing the form of option to be issued. Such permit will also authorize issue of options for a period of not to exceed one year after date of the permit at an exercise price per share alleged in the application and satisfactorily proved.

2. Thereafter, it may apply for yearly extensions (amendments) of the permit at exercise prices duly alleged and proved.

3. The filing fee for an application for amendment is as stated in Section 2603.19 of Article 3, supra. Other portions of said Article are also applicable, especially Sections 2603.06–2603.11.

C. Applicant may obtain a permit authorizing the issuance of options at a named initial option price, during a designated term, conditioned on clearance by the Commissioner of any subsequent issue of options for a different option price. Clearance will be presumed if the Commissioner does not reject the new price within 30 days after applicant has filed with him a notice, supported by appropriate proof, of the new option price. As an alternative to clearance of subsequent option prices by the Commissioner, applicant may propose the determination of such subsequent option prices by the Board of Directors or Option Committee in accordance with a formula. If the Commissioner finds such formula will result in the fixing of an actual price which will be fair, just and equitable, he will authorize its use in lieu of requiring that he pass upon the actual option price subsequently determined. If the stock to be optioned is shown to the Commissioner's satisfaction to have an established market, the formula may be in terms of averages of bid and asked prices at such times and places as to assure that true free market values will result from application of the formula. The foregoing method may be used in appropriate cases to procure authorization for issuance of options at 100% of fair market value of the shares optioned; or, in appropriate cases at some other figure fixed with reference to the fair market value. If a reliable market has not yet been established to the Commissioner's satisfaction, other methods, or combinations of methods to determine fair, just and equitable values will be considered.

Submission of at least annual reports of transactions will, in either event, be required.

§ 2608.06. Life Agents Production Stock Options Plans.

In order to be found fair, just and equitable, any plan of this nature shall ordinarily do not less than the following:

A. Be clear and unambiguous in its terms and as simple as the subject matter permits.

B. Provide that it shall be submitted to and approved by company's directors and stockholders before it becomes effective. Any definitive permit approving such a plan will require said prior submission and approval as a condition precedent to effectiveness of the authorization. The Commissioner may require satisfactory evidence that full and fair disclosure of outstanding options, the details of the plan and its intended operation was made to the stockholders prior to their approval of the plan.

C. Provide that no securities (either rights to options or options) will be issued thereunder without a prior permit of the Insurance Commissioner authorizing such issue; that company will promptly and diligently endeavor to procure the necessary authorizations contemplated by the plan.

D. Provide that business written will serve as a basis for earning options only after such business shall have been in full force and effect for three full policy years and premiums thereon for such period shall have been fully paid. Prepayment of premiums shall not accelerate the running of the persistency period. A policy that terminates in a death claim prior to expiration of the persistency period may be regarded as having run the full three years.

E. Govern the earning of conditional rights to options and the grant of options by a conservative formula based on one of the following:

1. The amount of premiums written (adjusted to an annual premium payment basis) and paid on policies issued during a given calendar quarter;

2. Commissions earned per calendar quarter; or

3. Some other reliable criterion of production of business (per calendar quarter) having intrinsic value to the company.

F. Provide for notifying each participating agent with reasonable promptness after the close of each calendar quarter of the number of shares to which he has earned conditional rights by virtue of his production for such calendar quarter, according to the stated formula. Such notification shall constitute evidence of his conditional rights to receive options for an appropriate number of shares after expiration of the persistency period and subject to all other conditions precedent. No form of said notification shall be used without prior approval thereof in writing by the Insurance Commissioner.

G. Provide for the issuance of options with reasonable promptness after expiration of the persistency period, according to the formula applied to business produced during the particular quarter, and subject to fulfillment of all other conditions precedent.

H. Specify that options to be granted thereunder shall be exercisable for not longer than 180 days after issuance thereof after which they shall become null and void.

I. Specify that options granted thereunder shall be nonassignable and non–transferable except by will or by the laws of descent and distribution.

J. Limit the maximum number of shares optionable at any given time to a number equivalent to 10% of company's then issued and outstanding shares.

K. Provide that options shall not be granted to any agent on the basis of personal or controlled business.

L. Provide in effect that agents appointed by the same company shall not transact insurance on each other or on each other's families for the purpose of avoiding the foregoing provision.

M. Provide that no agent shall be required to purchase any insurance on himself or his family in order to participate therein.

N. Provide for determination of price by a method appropriate to the company as set forth in the next succeeding section hereof.

O. Provide that rights to options for shares ostensibly earned by an agent's production, in accordance with the production formula, shall abate pro-rata at conclusion of the persistency period and prior to issuance of the actual options in any case where issuance of options otherwise required by rights earned would exceed the amount authorized by permit of the Insurance Commissioner.

P. Specify, and require options to be issued thereunder to specify, that, after due notice to the persons concerned and hearing, the Commissioner may for cause modify or terminate any or all of the following upon a finding as hereinafter indicated with respect thereto:

1. The plan, upon a finding that continuation thereof is unfair, unjust or inequitable.

2. Rights to options, upon a finding that issuance of options upon maturity thereof is or will be unfair, unjust or inequitable.

3. Outstanding (issued but unexercised) options, upon a finding that issuance of shares upon exercise thereof is or will be unfair, unjust or inequitable.

§ 2608.07. Price.

The exercise price to be stated in options issued pursuant to an authorized plan of the kind described in Section 2608.06, supra, shall bear a reasonable relationship to the actual value of the shares to be optioned. "Reasonable relationship" is understood to be not less than 75% of such value and not so great as to be unfair, unjust or inequitable. Actual value shall be determined in a manner appropriate to the status of the company as found by the Commissioner in accordance with the following:

A. In the case of an insurer which alleges and proves to the Commissioner's reasonable satisfaction that its shares, through substantial trading in a free market involving willing sellers and willing and able buyers, have achieved a recognized value in the market place; the plan shall provide that:

1. Company will average bona fide trading prices in the last available reported transactions on not less than one trading day per month each month during the production quarter. The selection of such trading day shall be on a consistent basis. The application for price clearance shall state such price so found and substantiate the same by reasonable evidence.

2. Company shall with reasonable promptness after expiration of each calendar quarter report such price to the Commissioner, and apply for clearance of the price related thereto (rounded off to the nearest tenth of a dollar) which it proposes under the plan to state in options ultimately to be issued after expiration of the persistency period, such options to be based on production during the quarter to which the price relates.

3. If the Commissioner does not within 30 days thereafter object, said price shall automatically, after expiration of 30 days from and after receipt by the Commissioner of such application for price clearance, be deemed acceptable. Whereupon, or upon specific clearance thereof, company will proceed to notify its agents of their production during such calendar quarter and the conditional rights which such production has ostensibly earned according to the formula.

B. In the case of an insurer which is unable to allege and prove to the Commissioner's reasonable satisfaction that its shares have achieved a recognized value in the market place as described in Paragraph A of this Section 2608.07, the plan shall provide for an appropriate mathematical formula, concurred in by the Commissioner, for determination of price pending such time as the Commissioner shall agree that said insurer's publicly traded stock has attained the status described in Paragraph A of this Section. Such formula shall:

1. Take into account at least the following items:

(a) capital and surplus

(b) non-admitted assets

(c) agency force

(d) value of business on its books.

2. Give recognition to company's age and the persistency of its business.

3. Provide that as company progresses in age and financial condition and its shares are publicly traded in increasing volume, such recognition as is concurred in by the Commissioner shall be given to the price arrived at in the market place. (Prices artificially created, influenced or sustained in a rigged or controlled market will not be accorded weight by the Commissioner.) (Secs. 839, 843)

§ 2608.08. Directors' Resolution as to Fairness of Price.

Any application for authorization to issue options, whether pursuant to a plan described in this Article or otherwise, shall be supported by a certified copy of a resolution of applicant's board of directors containing its findings, as follows:

A. In the case of an applicant who alleges and proves to the Commissioner's reasonable satisfaction that its shares have, through substantial trading in a free market involving willing sellers and willing and able buyers, achieved a recognized value in the market place—that the market price reported as a bona fide market price; that in the opinion of its board of directors said price represents the fair value of the shares; and that such issuance at the proposed price will be fair, just and equitable to the company, to its present and future stockholders, and to other optionees.

B. In the case of an applicant which is either newly organized, or, if not newly organized, whose shares have not yet achieved a recognized value in the market place as described in Paragraph A of this Section—that the value of the shares as stated represents, in the judgment of its board of directors, the true, fair value of the same; and that the option price sought to be authorized is a fair, just, and equitable price with respect to the company, to its present and future stockholders, and to other optionees.

Article 9. Miscellaneous Requirements

§ 2609.01. Capital Stock, One Class Of.

Complex capital structures involving more than one class of capital stock are disfavored. (Secs. 839, 843)

§ 2609.02. Shares of Stock, Par Value Of.

All shares of insurance companies admitted or to be admitted must have a specified par value. (Sec. 690. Does not apply to noninsuring "insurers.")

§ 2609.03. Shares of Stock, Price Of.

A. The price per share of the initial issue of stock of a newly organized domestic insurer, as "insurer" is defined by Insurance Code Section 826 and paragraph C of Section 2601.02 of these regulations, shall be not less that $50.00 a share. (Secs. 839, 843)

B. Absent special circumstances compelling the same, stock splits or other actions to reduce the value and price of its shares will not be authorized for a domestic insurer unless and until:

1. It has filed successive annual statements with the Department which, after audit, constitute satisfactory evidence in the Commissioner's judgement that the applicant's operations have been and are financially safe; and

2. Its shares have acquired a reasonably stable value in the market place. (Section 839)

C. Permits authorizing already licensed and operating foreign insurance companies to sell their shares in this State at less than $50.00 a share,

except in pre–emptive or comparable offerings, will not ordinarily be granted unless the applicant and its shares shall have attained the condition described in paragraph B of this section relating to domestic insurers. (California Constitution, Article XII, Section 15) The Commissioner will rely on financial statements (after audit) filed in this state if the applicant is admitted. A nonadmitted foreign applicant may prove its financial condition by copies of its annual statements filed with the regulatory authority of its home state, such copies to be certified by him as true copies of the same on file in his office. Such statements shall be subject to reasonable audit by this Department.

D. Newly organized foreign applicants for permits to offer their securities in this state shall be subject to requirements not more favorable to the transaction of such business than are comparable domestic applicants under the preceding paragraphs of this section. (California Constitution, Article XII, Section 15)

§ 2609.04. Price—Fair, Just and Equitable.

The following general principles are observed in the determination of price:

A. The price stated in the application of an operating but unseasoned insurer will be judged with reference to Section 839 by the tangible results produced by applicant with the surplus expended during the time it has been in business. (Secs. 839, 840)

B. Market transactions of significant volume in a free market are given primary weight.

C. In the case of stocks widely traded, allegation of current bid and asked prices is usually sufficient in the absence of recent substantial fluctuations.

D. Where there is an impending merger or some other factor strongly influencing market price, the showing of market transactions should extend from a period antedating such influence down to the filing date, or as near thereto as practicable. (Secs. 839, 843)

E. In the case of an operating insurer whose stock is substantially traded but has not acquired a stable market price, the application should be supported by evidence covering a period of usually not less than three months showing approximately the number of shares traded and the prices paid. (Secs. 839, 843)

§ 2609.05. Certificate for Shares, Contents Of.

Every form of certificate for shares submitted for authorization shall make provision for stating all of the following:

A. The name of the record holder of the shares represented thereby.

B. The number, designation, if any, and class or series of shares represented thereby.

C. The par value of the shares represented thereby if applicant is subject to Section 690 of the Insurance Code; otherwise, the par value, if any, of the shares represented thereby, or a statement that the shares are without par value.

NOTE: Underwritten title companies, attorneys in fact of reciprocal insurers, and exclusive managers of domestic insurers are not subject to said Section 690. (Sec. 690 and Corporations Code Sec. 2401)

§ 2609.06. Certificate for Shares, Not to Be Misleading.

Inclusion on share certificates of a caption stating "$_____ Capital" is regarded as misleading unless the amount of capital paid in is equivalent to the figure shown therein. Captions of this nature desired to be included on share certificates may state "Authorized Capital $_____." (Sec. 843)

§ 2609.07. Expense Ratio.

A permit will not issue where the Commissioner finds:

A. In the case of an application by a domestic insurer, as "insurer" is defined in Section 826 of the Insurance Code, for an organizational permit, that all expenses of every kind (including but not limited to expenses of incorporation, promotion, stock selling, legal and filing fees, commissions, costs of printing, engraving and postage) from incorporation to and including the obtaining of a certificate of authority chargeable currently or in the future to applicant for matters occurring prior to the issuance of a certificate of authority will exceed 10% of the total amount actually to be paid for applicant's securities. Assumption of any of such expenses by a person other than the applicant is not deemed to avoid the ban of the statute. (Secs. 839.5, 715 and 843). Obligations attempted to be incurred by the promoters for applicant, or incurred by the Directors on applicant's behalf for durable goods, equipment or facilities having a permanent usable value to an operating insurer, prior to issuance of a certificate of authority and without the Commissioner's prior authorization and disclosure in the prospectus, are regarded with disfavor.

B. In the case of a domestic insurer's application for other than an organizational permit, that all expenses of the stock sale (including but not limited to promotion, stock sales commission, printing, engraving, postage, legal, accounting, auditing and governmental filing fees) will exceed 10% of the amount actually to be paid for applicant's securities. Assumption of any of such expenses by a person other than the applicant is not deemed to avoid the ban of the statute. (Secs. 839.5, 843)

C. In the case of a foreign applicant, that the expenses described in A. or B. above, as appropriate, are such as to make applicant's plan of business unfair, unjust, or inequitable, or are such in the Commissioner's opinion that the sale of applicant's securities under the circumstances will work a fraud upon the purchasers thereof or upon other stockholders of applicant. Applications revealing such an expense ratio in excess of 10% are regarded with disfavor and will normally be disapproved on the grounds that to do otherwise would be to allow such foreign applicants to do business in California under terms and conditions more favorable than are domestic applicants. Assumption of any of such expenses by a person other than the applicant is not deemed to avoid application of any lawful rule in this respect. (Section 843 and California Constitution, Article XII, Section 15).

D. Each application for a securities permit and each authorized issue shall be judged independently insofar as expense ratio is concerned. There shall be no carryover from one issue to another of an unused allowance or of an overage; and there shall be no averaging of expenses between or among transactions authorized by successive permits.

§ 2609.08. Holding Company Expenses Included.

In calculating the expenses described in the preceding section, holding company expenses shall be included. Where organization of a holding company and its subsidiary or subsidiaries are not substantially concurrent, such expenses attributable to the holding company as may be reasonably and fairly allocated to the insurer applicant shall be included. In determining what is "substantially concurrent" the practicabilities of the situation and the objective of the holding company for the reasonably foreseeable future will be considered. (Section 715)

Article 10. Underwritten Title Companies and Other Noninsuring "Insurers"

§ 2610.01. Purpose and Scope.

As may be seen from Insurance Code Section 826, Chapter 395 of the Statutes of 1965, effective September 17, 1965, extended the definition of "insurer" as used in the Insurance Securities Law to include underwritten title companies, attorneys–in–fact of reciprocal or interinsurance exchanges, and exclusive manager of domestic insurers. Compare paragraph C of Section 2601.02 of these regulations which accurately states the Insurance Code definition.

Because a distinction has to be made in nomenclature throughout these regulations to differentiate between the old type of entities organized to assume the risk of loss under contracts of insurance and the three newly included types of noninsuring "insurers," the term "insurance company" is used herein to designate the former type; refer to paragraph F of Section 2601.01 of these regulations. Where the Insurance Code term "insurer" appears, it is employed in the full statutory sense and includes both types; refer to paragraph C, ibid.

The remainder of this article is devoted to pointing out those portions of these regulations which do and which do not apply to underwritten title companies, attorneys–in–fact of reciprocal insurers and exclusive managers of domestic insurers. This article should produce the same result as mere reliance upon the distinguishing terminology in the text of these regulations, and vice versa.

§ 2610.02. Articles and Sections of Regulations Applicable.

Insofar as the nature of the subject matter permits and unless otherwise specifically provided by law, the following portions of these regulations apply to underwritten title companies and other noninsuring "insurers":

Article 1
Article 2
Article 3, except paragraph A. of Section 2603.14. In connection with this section see also Section 2610.03, infra.
Article 4
Article 5, the first sentence of Section 2605.01; paragraph B.of Section 2605.02; and, if applicable, paragraph C., ibid; Sections 2605.03 and 2605.04. In connection with Section 2605.01, see also Section 2610.03, infra.
Article 6
Article 7
Article 8, Sections 2608.01 through 2608.05, and 2608.08.
Article 9, except Section 2609.02.
Article 11 and
Article 13.

§ 2610.03. Proving Required Minimum Capital and Surplus or Net Worth.

A. The application of an underwritten title company applying for a securities permit, unless applicant possesses the largest amount of capital and surplus or net worth specified by Insurance Code Section 12396(a)(1) appropriate under the circumstances, shall allege and prove to the Commissioner's reasonable satisfaction:

1. The names of all of the counties wherein applicant is transacting any business of examining public records affecting titles to real property, preparing reports of title searches, certificates or abstracts of title, upon the basis of which a title insurer regularly issues policies of title insurance.

2. With respect to each county named pursuant to subparagraph (1) above, the serial number stamped by the County Recorder on the last document recorded by him in the official records of his office on the last recording day of the calendar year preceding the filing with the Commissioner of such application (i.e., the total number of documents so recorded in said year). The Commissioner will accept a letter from a County Recorder setting forth such information as satisfactory proof. This provision does not foreclose or prevent other methods of proving such number to the Commissioner's satisfaction.

3. The total of all of the numbers alleged pursuant to subparagraph (2) above.

B. Paragraph A of this Section shall not be deemed to restrict the meaning of the phrase ". . for each county in which it operates" as such phrase is used in Insurance Code Section 12396(b)(3) governing deposit of securities with the Commissioner by an underwritten title company as a prerequisite to engaging in the escrow business.

Article 11. Reports of Transactions

§ 2611.01. Report of Transactions Required.

Reports of Transactions shall be made in duplicate and shall be sworn (or, where so authorized by statute in the place where the verification is made, certified under penalty of perjury) to be true and correct. They shall allege sufficient facts to show the following:

A. The number and amount of each kind of securities sold.

B. The gross proceeds and the net proceeds of such sale.

C. The disposition of such proceeds.

D. Whether conditions of the permit governing the authorized transactions were complied with.

E. In the case of preorganization, soliciting or negotiating permit, the results of the authorized action.

F. Any other specific information required by the permit. (Secs. 844, 843)

§ 2611.02. Report of Transaction to Be Captioned, Entitled and Labeled.

Every Report of Transaction shall be captioned as specified in Section 2603.07 for applications. It shall bear the same entitlement as a properly entitled application in the matter reported on (refer to Sec. 2603.08, ante). It shall be plainly labeled "REPORT OF TRANSACTIONS" if the instant report is the only report to be filed; otherwise, it shall be labeled "FIRST REPORT OF TRANSACTIONS," "SECOND REPORT. . . .," etc., "PRELIMINARY REPORT. . . .," etc., "INTERIM REPORT. . . .," etc., or "FINAL REPORT. . . . ," etc., as may be appropriate under the circumstances.

§ 2611.03. Report of Transactions, to Be Timely Filed.

Applicants should take care to make and timely file the verified report of transactions in duplicate lawfully required by the permit, since failure to do so is a violation which could give rise to litigation and may have other consequences. (Secs. 844, 833(i), 843) The Commissioner may withhold favorable action on a subsequent application until any material delinquency with respect to a prior report has been remedied.

Article 12. Contribution Certificates

§ 2612.01. In General.

Applications for permits to issue contribution certificates are customarily granted authorizing sale of such certificates to financially interested parties under conditions requiring emergency financing. Contribution certificates only evidence a contingent promise to repay; they are not regarded as a commercially salable security.

Such form of evidence of contribution (not an "evidence of debt" in the sense commonly understood) will not ordinarily be authorized in denominations of less than $5,000 and their sale to the general public will not be permitted. (Secs. 839(a) and (c), 843)

§ 2612.02. Form of.

The body of the form of contribution certificate, when authorized, shall be substantially as shown herein. The following form is for an inter-insurance exchange; other entities having to resort to this device shall adapt the substance thereof.

ABC INSURANCE EXCHANGE
1 Market Street
_____, California

CERTIFICATE OF CONTRIBUTION

Certificate No. _____

THIS IS TO CERTIFY THAT XYZ UNDERWRITERS (hereinafter called "Contributor"), Attorney–in–Fact for ABC INSURANCE EXCHANGE, has advanced to ABC INSURANCE EXCHANGE, a reciprocal insurer (hereinafter called the "Exchange"), the sum of _____Thousand Dollars ($_____) in cash, lawful money of the United States (hereinafter called the "Principal Sum").

I

This Certificate of Contribution is used pursuant to the authority granted by Permit No._____ of the Insurance Commissioner of the State of California and is hereby designated "Certificate Number _____"*

II

The Principal Sum of this Certificate, to wit, _____Thousand Dollars ($_____) shall, upon presentation of this Certificate for endorsement of any partial payment, or upon complete surrender for cancellation in return for final payment in full, be payable by the Exchange at its Home Office at _____, California, only out of the excess of the admitted assets of the Exchange over the sum of:

1. All liabilities (including, but not limited to claims, losses, reserves, reinsurance, dividends, production and administrative expenses, taxes, loans, and advances), but excluding any amounts for or on account of any outstanding Certificates of Contribution, including this Certificate; and

2. An amount (of surplus) equal to the largest of (a) or (b) or (c) hereinafter:

a) One and one–half times the amount required by the laws of California at the time of such repayment for the issuance of a Certificate of Authority to transact the classes of insurance which it is then transacting anywhere, or which it is authorized to transact in California, or the amount required by the laws of any other jurisdiction for the retention of its Certificate of Authority in that jurisdiction, whichever is the largest amount; or

b) In the event the exchange at the time of repayment of this or any other Contribution Certificate has any non–assessable policies outstanding, an amount equal to one and one–half times the minimum paid–in capital required of incorporated insurers issuing policies on a reserve basis and transacting the same classes of insurance; or

c) $_____

*NOTE: In any case here contribution certificates are to be issued to more than one lender, a paragraph or paragraphs will be inserted containing the following provisions and information:

There are _____certificates in an aggregate amount of $_____ already issued and outstanding that are senior to all certificates bearing the same issue date as this certificate bears. _____certificates in an aggregate amount of $_____ were issued on the same date as this certificate.

III

The Principal Sum of this Certificate shall not be payable in whole or in part, except upon approval in writing by the Insurance Commissioner given after the decision of a majority of the Governing Board of the Exchange made and recorded at a regular or special meeting; provided, however, that the Governing Board of Exchange shall be required to exercise such option and vote payment of such Principal Sum, either in whole or in part, whenever the condition of the Exchange is such that it no longer reasonably requires the sum proposed to be paid upon the Principal Sum of this Certificate.

IV

Interest at the rate of _____% per annum, not compounded shall be due and payable semi–annually by the Exchange at its Home Office at _____, California upon the unpaid balance of the Principal Sum of this Certificate to the extent, and only to the extent, that funds of the Exchange exist on each such due date to discharge all liabilities within the meaning of Paragraph II (1) herein above plus the sum of $_____ (the minimum surplus required by law to be maintained over and above all liabilities for the classes of insurance it is transacting) or the amount of surplus required by the laws of any jurisdiction in which it is licensed to do business to retain unimpaired its Certificate of Authority there, whichever is the larger amount. If no such funds in whole or in part exist on any such due date, such interest for which no funds for payment exist shall not become due or payable but shall accrue and shall become due and payable when and to the extent such funds do come into existence thereafter. Any interest both due and payable by the terms of this paragraph shall create a cause of action in the Contributor and be a liability of the Exchange.

V

The obligation evidenced by this Certificate shall not be a liability or claim against the Exchange or its funds or assets at any time except to the extent that the Principal Sum hereof, in whole or in part, shall be due and payable in accordance with the provisions of Paragraphs II and III hereof and except to the extent that interest on this Certificate, in whole or in part, shall be due and payable in accordance with the provisions of Paragraph IV hereof.

VI

Should the Exchange at any time discontinue the insurance business, then, after the payment or provision for payment of all the obligations described in subdivision (1) of Paragraph II hereof, following the determination of such facts by the Insurance Commissioner of the State of California, any remaining funds or assets of the Exchange shall first be applied to the payment of any interest accrued hereon, then to the remaining unpaid balance of the Principal Sum of this Certificate.

**VII

Nothing in this shall be construed to prevent the Governing Board of the Exchange from declaring and paying dividends or savings to the policyholders in the manner and to the extent permitted by law.

VIII

It is understood and agreed that the Contributor has made the foregoing contribution upon the terms and conditions herein set forth, after having been furnished with a copy of the permit of the Insurance Commissioner of the State of California authorizing the issuance of this Certificate and having read the same, and that this Certificate evidences the complete understanding and agreement between the Contributor and the Exchange.

IN WITNESS WHEREOF, ABC INSURANCE EXCHANGE has executed this Certificate
at _____, California, this _____ day of _____, 19_____.

ABC INSURANCE EXCHANGE
By_____
Chairman–Board of Governors

_____
Secretary

APPROVED AND ACCEPTED:
XYZ UNDERWRITERS, Contributor
By _____
President
By _____
Secretary

**See above Note and the following paragraph:
The order of repayment of this and other contribution certificates bearing the same date hereof shall be simultaneous in time and equal in amount. This certificate and others, if any, issued on the same date as this certificate shall be senior to other contribution certificates that may be issued hereafter, and junior to already issued and outstanding certificates.

STATE OF CALIFORNIA }
COUNTY OF _____ } ss

On this _____ day of _____, 19_____, personally appeared_____ _____ and _____ known to me to be the person whose names are subscribed above as Chairman and Secretary, respectively, of ABC Insurance Exchange, and they and each of them duly acknowledged to me that they and each of them executed this instrument pursuant to authority granted by the Board of Governors of ABC INSURANCE EXCHANGE.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal this day and year.

Date _____.

_____
Notary Public in and for said
County and State

"RESOLVED:
That _____ and _____ are hereby authorized to apply to the Insurance Commission of the State of California for authority to issue (additional) Contribution Certificates of ABC Insurance Exchange to XYZ Underwriters in an amount not to exceed $ _____."

STATE OF CALIFORNIA }
COUNTY OF _____ } ss

_____, being first duly sworn, deposes and says:
That he is the Assistant Secretary of the Board of Governors of ABC Insurance Exchange; and that the resolution stated above was passed and adopted by the Executive Committee of the Board of Governors of ABC Insurance Exchange at a special meeting on _____, _____ 19_____.

Subscribed and sworn to before me this _____ day of _____19_____.

_____
NOTARY PUBLIC in and for the County of _____
State of California
My Commission expires _____

§ 2612.03. Application to Be Made by Exchange.

In the case of borrowing by a reciprocal or inter–insurance exchange, an application for authorization to issued and sell contribution certificates shall be made by the exchange itself, rather than by the attorney in fact. Application for the Commissioner's approval to pay outstanding contribution certificates shall likewise be made by the exchange.

§ 2612.04. Interest Rate On.

The rate of interest to be paid for such borrowing is a matter of private contract, but agreement to pay an excessive rate may invoke the ban of

Section 839. Absent unusual circumstances, a rate of not more than 1 1/2 % above the prevailing prime bank rate is not regarded as excessive. (Secs. 839, 843)

§ 2612.05. Reporting in Annual Statements.

A permit authorizing issuance of contribution certificates will provide substantially as follows:

In any financial statement required by law to be filed by applicant with any public officer, or which may be published or distributed by applicant, the principal sum of and accrued interest on these and any other outstanding contribution certificates, which has not become a liability in accordance with the terms thereof and is not reported in such financial statement as a liability, shall be reported according to the appropriate "Instructions for Completing Fire and Casualty Annual Statement" blank promulgated by the Insurance Commissioner. Such amount shall be reported on the appropriate line on page 3 of the annual statement either as "contribution certificates," "outstanding contribution certificates," or "contributed surplus." Other descriptions, such as "debentures," "surplus notes," "guaranty fund," or "guaranteed certificates," are deemed misleading and are not permitted.

Article 13. Forms and Addenda

§ 2613.01. Application for Permit Authorizing Rights Offering.

For the convenience of attorneys at law unfamiliar with the customary style and manner of drafting California applications, a sample of an average, successful application by a foreign insurer for a permit to make a rights offering is furnished herewith:

BEFORE THE INSURANCE DEPARTMENT
OF THE
STATE OF CALIFORNIA

In the Matter of the Application of
XYZ INSURANCE COMPANY,
New York, New York
For a Permit Authorizing the Sale
and Issuance of Its Securities

FILE NO. _____
FILED: _____
APPLICATION
FOR PERMIT

TO THE INSURANCE COMMISSIONER OF THE STATE OF CALIFORNIA:
The application of XYZ Insurance Company respectfully shows:

I

Applicant was duly incorporated under the laws of the State of New York on July 1, 1910, and ever since has been and now is in good standing in said State.

II

Applicant was duly authorized to transact the business of insurance in its home state on August 2, 1910, and in the State of California on September 6, 1928; and ever since said dates has continued to transact insurance business in said states, respectively. Applicant is now duly admitted in 49 states.

III

Applicant's domiciliary and executive offices are located at 99999 Lexington Avenue, New York City, 10017.

IV

The names and addresses of Applicant's officers and directors are listed on pages 14–15 of the Prospectus hereinafter referred to.

V

An itemized account of Applicant's financial condition and a detailed statement of its plan of doing business are found in its current (1965) annual statement and its latest report of examination (as of December 3, 1964) on file with the Insurance Commissioner of the State of California, and they are hereby incorporated herein.

VI

The securities to be issued are:
Transferable subscription warrant with fractional share buy and sell order form, marked "Exhibit A."
Specimen certificate for shares (voided), marked "Exhibit B."
Said exhibits are by this reference incorporated herein.

VII

The prospectus, President's letter to stockholders, and all other non-individual and non-unique communications concerning or descriptions of the securities which Applicant has prepared to distribution or publication are attached hereto, labeled as indicated, and are by this reference incorporated herein:
Preliminary prospectus dated March 1, 1966, "Exhibit C."
President's letter to shareholders, dated March _____, 1966, "Exhibit D."

VIII

No underwriters or other brokers will participate in this offering, and Applicant has not entered into and will not enter into any contract with underwriters or brokers in connections with this issue.

IX

A certificate in good standing issued by the New York Superintendent of Insurance within 30 days prior to the filing of this application is attached hereto, marked "Exhibit E," and is by this reference incorporated herein.

X

A current appointment by Applicant of the California Insurance Commissioner and his successor in office as agent for service of process as required by California Insurance Code Section 837(b) is attached hereto, marked "Exhibit F," and is by this reference incorporated herein.

XI

Applicant proposes, on or about March 25, 1966, and continuing for thirty days, to make a rights offering to its California stockholders of record on March 1, 1966. Subscription rights will be evidence by transferable subscription warrants like Exhibit A, each designating the total number of rights to which the shareholder is entitled on the basis of one right for each share of stock held as of the record date. Ten rights will be required to subscribe for each new share of Applicant's $12.50 per value capital stock. No underwriters will participate in this offering, and a privilege of over subscription will be available to offerees wishing to subscribe for shares not taken up through the exercise of primary subscription rights. For further details of the terms of the offer and the time within which it is expected to be made, reference is made to "offer to Stockholders" on pages 3 and 4 of the prospectus, Exhibit C.

XII

Registration Statement, Form S–1, and Amendments Nos. 1 and 2 are also attached hereto, marked "Exhibit G–1," "Exhibit G–2," and "Exhibit G–3," respectively, and they are by this reference incorporated herein. Registration with the Securities and Exchange Commission is expected to become effective 10 A.M. on Friday, March 25, 1966. Duplicate copies of the registration and final prints of the subscription warrant form and of the President's letter to stockholders will be mailed to you for filing herein as substituted exhibits as soon as they are available after such effective date.

XIII

As of a recent date there were 907 stockholders of Applicant with California addresses of record. Said stockholders held an aggregate of 4,800 shares of applicant's capital stock. Allowing a margin of safety on account of migratory stockholders and because of trading in warrants due to the later closing hours of stock exchanges in California in reference to Eastern stock exchanges, Applicant believes that a permit for 5,000 shares will be adequate.

XIV

Applicant's capital stock is widely traded and transactions therein are reported daily in newspapers of nationwide circulation. Recent price ranges are shown on page 17 of Exhibit C. The closing price on the New York Stock Exchange the day before the date of this application was $87. The offering price to Applicant's stockholders will be $3 below the expected market price when registration with S.E.C. becomes effective, or approximately $84. Applicant will notify you by telephone, confirmed by air mail letter, of the effective date and price per share.

The filing fee paid upon the filing of this application was computed on the basis of 5,000 shares valued at $87, or a total value of $435,000.

—oOo—

WHEREFORE, Applicant respectfully requests the Insurance Commissioner of the State of California, as soon as reasonably possible after receipt of notice of the offering price and filing herein of duplicate copies of the aforementioned substituted exhibits, to issue his permit authorizing Applicant to offer, sell and issue not to exceed 5,000 shares of its $12.50 par value capital stock for the uses and purposes, and in the time and manner described in Exhibit C.

Dated at New York, N.Y., this 15th day of March, 1966.

XYZ INSURANCE COMPANY
By John J. Smith
President

(Verification as in
Sec. 2603.10, supra)

§ 2613.02. Application for Permit to Exchange Shares.

For the guidance of out–of–state attorneys or other unfamiliar with the style of applications for California insurance securities permits, the following composite example of an application by a non–admitted foreign insurer for a permit to offer and exchange securities is furnished:

BEFORE THE DEPARTMENT OF INSURANCE
OF THE
STATE OF CALIFORNIA

In the Matter of the Application of ACME INSURANCE COMPANY, Nome, Alaska For a Permit Authorizing Applicant to Offer and Exchange Its Shares of Capital Stock	ss	FILE NO._____ FILED_____ APPLICATION FOR PERMIT

To the Insurance Commissioner of The State of California:

ACME INSURANCE COMPANY, an Alaskan insurer not admitted to the State of California, with its home office in The Acme Building at 100 "A" Street in the City of Nome, State of Alaska, hereby applies for a permit authorizing it to offer to the California resident shareholders of Ace Insurance Company, Fairbanks, Alaska, to exchange, not to exceed 5,000 shares of Applicant's $10.00 par value capital stock for the shares of Ace Insurance Company's $5.00 par value capital stock owned by said California shareholders, at the rate and on the basis of 1 share of Applicant's stock for each 2 shares of Ace Insurance Company stock. The present market price of Ace Insurance Company shares is $11.22 per share as shown by page 23 of Exhibit I; and the total consideration expected to be paid or exchanged for Applicant's shares pursuant to the permit applied for is $112,200. The filing fee paid herewith is calculated on the basis of said $112,200.

I

In support of this application, Applicant attaches the following exhibits, which by this reference are incorporated herein, and alleges:

A. The names and addresses of applicant's officers and directors are set forth in Exhibit A.

B. An itemized account of Applicant's financial condition showing the amount and character of its assets and liabilities is supplied in Applicant's verified Convention form annual statement as of December 31, 1965. A signed, verified copy thereof certified by the Alaska Insurance Commissioner to be a true copy of the same on file in his office is attached hereto marked Exhibit B: Applicant's financial condition has materially changed since the date of said statement on account of Applicant's merger effective January 30, 1966, with A.A.A. Insurance Company, Sitka, Alaska, with Applicant as survivor. These additional exhibits show the terms and conditions, financial details and effect of said merger:–Exhibit C, a copy of the Agreement of Merger as approved and filed with the Alaska Insurance Commissioner and bearing his original, true copy certificate to that effect.

Exhibit D, an annual statement of A.A.A. Insurance Company as of said January 30, 1966, before merger.

Exhibit E, an annual statement of Applicant as of said January 30, 1966, before merger; and

Exhibit F, an annual statement of Applicant as of said January 30, 1966, after merger.

C. A detailed statement of the plan upon which Applicant transacts business is provided in last said annual statement and in the Alaska Insurance Department Report of Examination as of December 31, 1964, dated May 1, 1965, a copy of which, certified by the original certificate of the Alaska Insurance Commissioner to be a true copy of said report on file in his office, is marked Exhibit G.

D. A specimen copy of the certificate of shares of Applicant's $10.00 par value capital stock, which is the only security Applicant proposes to issue in this transaction, is marked Exhibit H.

E. There is no contract with underwriters or brokers. There will be no sale of stock for cash, merely an issue and exchange of shares of Applicant for share of Ace Insurance Company. No commissions or fees will be paid with respect to the distribution of shares asked to be authorized by the permit applied for.

F. The only writings describing the securities to be offered or other written solicitations for exchange of Applicant's shares are:

1. Exhibit I, Registration Statement, Form S–1 (including preliminary prospectus) under the Securities Act of 1933; and Exhibit J, Amendment No. 1 to said Registration Statement.
2. Exhibit K, the form of Acceptance of Offer, in duplicate.
3. Exhibit L, a letter of solicitation and transmittal of the Plan of Exchange and Acceptance of offer form by John Smith, President of Applicant herein, dated April 2, 1966, which is proposed to be mailed to all shareholders of both companies with the Prospectus on the day Applicant's registration with S.E.C. becomes effective, which is expected to be on or about April 1, 1966.
4. Exhibit M, a letter of solicitation addressed to all shareholders of Ace Insurance Company, Fairbanks, Alaska, by its President, Richard Roe, dated April 2, 1966, which is proposed to be mailed on its behalf to shareholders of record of that company.

G. A copy of Applicant's articles of incorporation as amended to date of this application, certified by the original certificate of the official custodian of the original thereof in the State of Alaska to be a true copy of the same on file in his office, is marked Exhibit N.

H. A copy of Applicant's by–laws certified over the signature of Applicant's Assistant Secretary, attested by its corporate seal, to be a true copy of the same as amended to date, is marked Exhibit O.

I. Certified copes (certified by the corporation Secretary, attested by its corporate seal) of the resolutions of applicant's Board of Directors and of its annual meeting of shareholders authorizing this offer and exchange and this application are marked Exhibits P and Q, respectively.

J. A certificate in good standing issued by the appropriate regulatory authority of Applicant's home state within 30 days prior to the filing of this application and showing that Applicant is duly authorized to transact business in that jurisdiction, is marked Exhibit R.

K. A properly executed, duly acknowledged power of attorney irrevocably appointing the California Insurance Commissioner and his successor in office as Applicant's true and lawful attorney upon whom all process in any action or proceeding against it can be served with the same effect as if the Applicant were a California Domestic insurer lawfully served with process in the State of California, is market Exhibit S. The certificate of conformity of the Clerk of an Alaska court of record as required by California Civil Code Section 1189 is attached to the Notary's certificate of acknowledgement at the foot of said power of attorney.

II

Applicant transacts multiple lines of insurance, as may be seen from its annual statement. Operations are and have been profitable. The purpose of the offering herein sought to be authorized is to acquire the shares of Ace Insurance Company and eventually merge that corporation into Applicant. Such merger will result in acquisition of additional agents and business and tend to reduce unit cost of operation. After such acquisition and merger, Applicant intends to continue to operate as at present.

III

With respect to the fairness, justness and equitableness of the ratio of exchange, reference is made to the following pages of the Plan of Exchange for comparative data about the two insurers under these topics:

History and Business p.13
Growth and Assets and Premiums Written p.14
Loss and Expense Ratios p.14
Management and Investment p.15
Balance Sheets ..... pp. 16–17
Profit and Loss Statements ..... pp. 18–19
Surplus Statements and Book Value ..... pp. 20–22

See also page 23 for list of securities dealers making an over–the–counter market in the stock of either or both companies, and the bid and asked prices during the last six months.

Applicant further alleges that the price of its shares of capital stock in terms of the exchange offer is fair, just and equitable, and that the terms and conditions of the exchange offer are fair, just and equitable. According to the terms of the offer, no fractional shares will be issued. Provision is made for buying or selling fractions, as shown in the Plan of Exchange and The Acceptance of Offer form.

IV

Applicant believes that the averments made herein concerning said ACE Insurance Company are true and correct, said averments being made in reliance on information supplied by officers of said company and its officially filed reports and financial statements.

As of the end of the calendar month last preceding the filing of this application, there were, according to the books and records of the Ace Insurance Company, 110 of its stockholders with California addresses owning 9,100 shares of its capital stock. Allowing for a slight increase during the pendency of this offer as a margin of safety, Applicant needs a permit to offer not to exceed 5,000 of its shares.

* * *

WHEREFORE, Applicant respectfully requests that it be granted a permit until August 1, 1966, to offer to the California resident shareholders of Ace Insurance Company to exchange, and to exchange, in whole share lots, not to exceed 5,000 shares of Applicants' $10.00 par value capital stock for the share of the $5.00 par value capital stock of said Ace Insurance Company owned by said California stockholders on the basis and at the rate of 1 share of Applicant's stock for each 2 shares of Ace Insurance Company capital stock surrendered and tendered for exchange, fractional shares to be cared for as provided in the terms of the offer set forth in the Plan of Exchange.

Dated March 15, 1966, at Nome, Alaska.

ACME INSURANCE COMPANY
By John Smith
President

(SEAL)

Attest:

_____
Secretary

(Verification as in Section 2603.10, supra)

§ 2613.03. Permit Authorizing Exchange of Shares in Connection with a Merger.

For the information of those doing business with this department who are unfamiliar with the terms of permits issued by the Insurance Commis-

sioner, a simple example of a recent permit authorizing sale and exchange of shares in connection with a merger is provided, as follows:—

STATE OF CALIFORNIA
Department of Insurance

In the Matter of the Application of
AETNA LIFE INSURANCE COMPANY
a Connecticut Corporation,
For a Permit to Sell and Issue Its
Securities in California
PERMIT NO. SF-774

THE ISSUANCE OF THIS PERMIT IS PERMISSIVE ONLY AND DOES NOT CONSTITUTE A RECOMMENDATION OR ENDORSEMENT OF THE SECURITIES PERMITTED TO BE ISSUED HEREUNDER

Pursuant to its verified application filed herein October 22, 1964, and thereafter supplemented by additional and current exhibits, good cause therefore, appearing, I hereby authorize and permit

AETNA LIFE INSURANCE COMPANY

a Connecticut insurer with its home office at 151 Farmington Avenue, Hartford, Connecticut, duly admitted to transact life and disability insurance in the State of California, to sell and issue its securities in California for the uses and purposes stated in said application and the exhibits thereto, as follows:

AUTHORIZATION: To issue and exchange not to exceed 1,200,000 shares of applicant's new $2.50 par value common stock with California residents who own shares of The Aetna Casualty and Surety Company, Hartford, Connecticut, on the scheduled date of delivery. Such exchange shall be made in connection with the lawful consummation of a proposed merger of said The Aetna Casualty and Surety Company with and into Farmington Valley Insurance Company, Hartford, Connecticut (to be known as The Aetna Casualty and Surety Company from and after the effective date of such merger), substantially as disclosed by the exhibits on file herein; such exchange shall be made on the basis and at the rate of 1.9 shares of applicant's $2.50 par value capital stock for each $3.50 par value share of The Aetna Casualty and Surety Company stock surrendered and tendered in exchange, all in accordance with applicant's instructions to said stockholders substantially as shown by the exhibits on file herein.

THIS PERMIT IS ISSUED UPON THE FOLLOWING CONDITIONS AND IS EFFECTIVE ONLY AS TO TRANSACTIONS SUBJECT TO CALIFORNIA LAW PERFORMED IN CONFORMITY THEREWITH:

CONDITION ONE: No certificate for shares shall be issued except substantially in the text of the appropriate form or forms comprising Exhibit B (as amended December 2, 1964) to the application herein or substantially in the text of a certificate hereafter approved by the Insurance Commissioner.

CONDITION TWO: No commission, selling expense,or other remuneration is to be paid to any person in respect to any transaction authorized by this permit, except that the regular salaried employees of applicant may perform any and all acts necessary, convenient, or advisable in connection with the transactions authorized by this permit, and fees may be paid for the necessary services and expenses of legal counsel, transfer agents, stock agents, registrars, proxy solicitors or for services of a similar nature.

CONDITION THREE: No advertisement, proxy,or solicitation material of any nature concerning the securities hereby authorized shall be issued, circulated or published unless the same shall first have been filed in duplicate with the Insurance Commissioner and its use approved by him in writing. Papers heretofore filed herein have been approved for such purpose.

CONDITION FOUR: Applicant shall within 30 days from and after January 28, 1965 make and file with the Insurance Commissioner its verified report alleging the transactions had and done pursuant to authority hereof, including the total number of shares issued, the consideration received therefor, and the disposition thereof; also, whether the preceding conditions of this permit were complied with. In addition thereto, applicant shall file a further verified report of transactions upon completion of the transactions herein authorized; also at such other time as the Commission may request in writing.

CONDITION FIVE: The Insurance Commissioner may from time to time for cause amend, continue, or alter this permit, or temporarily suspend the rights of applicant hereunder, or may revoke this permit.

CONDITION SIX: Unless theretofore suspended or revoked, all authority to issue securities under this permit shall automatically expire upon completion of the transactions hereby authorized.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed by official seal *this 14th day of December, 1964.*

(SEAL)

Insurance Commissioner

§ 2613.04. Application by Domestic Corporation for Organizational Permit.

The following form represents a composite of several acceptable applications by domestic California corporations for organizational permits. Use herein for illustrative purposes of certain components of a plan of operation should not be regarded as an expression by this department of a preference in operational details.

BEFORE THE DEPARTMENT OF INSURANCE
OF THE
STATE OF CALIFORNIA

In the Matter of the Application of
ABC LIFE INSURANCE COMPANY,
San Francisco, California
For a Permit Authorizing Applicant
to see and issue its Securities
FILE NO. _____
FILED _____
APPLICATION FOR
ORGANIZATIONAL PERMIT

TO THE INSURANCE COMMISSIONER OF
THE STATE OF CALIFORNIA:

ABC LIFE INSURANCE COMPANY, a newly organized California corporation with its home office temporarily at No. 1 Market Street, San Francisco, California, was incorporated January 2, 1964, for the purpose of transacting a life insurance business (including the disability supplements described in Insurance Code Sections 10271 and 106), and to that end applies for a permit authorizing it to see and issue 80,000 shares of its $10.00 per value capital stock at a price of $50.00 per share, cash, lawful money of the United States so as to capitalize itself in order that it may be eligible to apply for an receive a certificate of authority authorizing it to transact the classes of life and disability insurance in the State of California.

In support of this application, Applicant attaches the following exhibits and by these references incorporates them herein and makes them a part of this application, and alleges:

I

Exhibit A is a copy of Applicant's articles of incorporation filed with the Honorable Secretary of State at Sacramento on January 2, 1964, originally certified by his Deputy to be a true copy of the same on file in his office.

II

Exhibit B is a copy of Applicant's by-laws certified by the original signature of Applicant's secretary and attested by its corporate seal to be a true copy of the by-laws currently in force.

III

The names and addresses of applicant's officers and directors are as follows:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV

Biographies of Applicant's officers, directors and key managerial personnel are attached hereto, marked Exhibit C-1 through C-11 and by this reference are incorporated herein and made a part hereof. Each of said biographies is on the Departmental form required by Paragraph B of Section 2605.01 and found in Section 2613.07 I.S.P.R. and is signed by the individual concerned and certified by him under penalty of perjury to be true and correct.

V

If its stock is sold successfully and Applicant is fully capitalized according to its plan as hereinafter set forth, and if Applicant is granted a Certificate of Authority by the Insurance Commissioner in response to due application therefor, Applicant intends to transact the usual business of a life insurer in the manner, with the means, and to the extent hereinafter shown and demonstrated by the exhibits attached hereto. In further elaboration of its plan of operation, Applicant alleges as follows:

A. Applicant can obtain adequate office quarters on the 15th floor of No. 1 Market Street, in the City of San Francisco, Applicant will retain (if it is successful in its stock sales and in obtaining a certificate of authority) the firm of White and Black as consulting actuaries who will supervise the setting up of Applicant's books and records and the operation of Applicant's internal office procedure, accounting and financial reporting until Applicant develops sufficient skilled personnel of its own to take over these functions.

B. Applicant will operated on the American Agency System through individual life and disability agents compensated by commissions in the usual manner, such agents to be supervised by general agents and home office personnel.

C. Applicant intends to transact only through duly licensed life and disability agents and will, if it is granted a certificate of authority by the Insurance Commissioner, initially appoint only experienced agents. It expects to recruit such agents from among the personal friends and acquaintances of its officers, directors, and key managerial personnel who have extensive acquaintance in the life insurance industry.

D. A sample General Agent's Contract form, and sample Agent's Contract form, each complete with commission schedules, are attached hereto, marked Exhibits D–1 and D–2, respectively.

E. Applicant expects to develop its business from the following sources: from such leads as its agents and others connected with the company can furnish; from vital statistics publicized in the press; from automobile registration lists, and other merchandising information that can be obtained readily; and by cold canvassing.

F. Applicant expects its agents to sell policies only by personal interview and advertising through the press; no solicitation by mail is planned. Agents will not be provided with "canned" sales talks; rather, agents will be instructed to sell directly from the policy or policies concerned. Applicant will use no "gimmicks" or trick devices in the sale of its policies.

G. No institutional advertising is presently planned; and any and all advertising proposed to be used by general agents or individual agents must first be submitted to and approved by the Company, as may be seen by reference to the contracts alluded to in paragraph D above. It is expected that Applicant ultimately will develop and provide its agents with certain brochures, advertising, and sales kits, all of which will be patterned after those employed by the Red, White and Blue Life Insurance Company of Sacramento, California, which Applicant is informed and believes, and therefore alleges, is a nationally known, reputable life insurer whose advertising conforms with all applicable California laws.

H. Applicant has reserved the right to supervise and control the sales techniques employed by its agents and general agents; reference may be made to the contract forms attached hereto as Exhibits D–1 and D–2.

I. Death claims will be paid either by mail or by local agents of Applicant upon receipt at Applicant's home office of acceptable proof of death of a policyholder; no compensation for such service will be paid to Applicant's agents. Claims under the disability supplements to individual life policies will be handled through Applicant's home office.

J. The salaries Applicant initially proposes to pay its officers are set forth in a schedule, marked Exhibit E, attached hereto. Directors will receive no salaries or fees for attending meetings during the first two years; however, it is proposed that their traveling expenses, if any, will be paid.

K. Applicant's investments will be managed by its Executive Vice–President who, as may be seen by referring to his biography in Exhibit C to this application, has had extensive experience in the investment field and is himself a financier of substantial means. Said individual is fully familiar with Insurance Code Sections 1153, 1153.5, 1170–1202 and with California Administrative Code Sections 2279 to and including 2283, such investment duties will be part of said officer's regular duties and will entail no extra compensation.

L. No officer, director, trustee, investment committee member, medical director, or actuary of the company, will receive directly or indirectly a commission on any business written for this Applicant.

M. Applicant has a procedure for ascertaining whether there will be any conflict of interest between the business of the Company and the private interests of its officers and directors. This consists of a confidential questionnaire answered under oath in writing by each such officer and director. A copy of the form thereof marked Exhibit F is attached hereto. Said questionnaire inquiries into all relevant financial business, stock and property interests and corporate directorships which might be affected within the scope of Insurance Code Section 1101 by any and all business which the Company transacts or will transact.

VI

Applicant's leading policy form is attached hereto as Exhibit G. It is a non–standard reducing term policy with a return–of–premium clause and a rider providing double indemnity for accidental death of either the policyholder or his beneficiary.

There is attached hereto, marked Exhibit H, an actuarial computation made and signed by a Fellow of the Society of Actuaries computing the reserves under Applicant's leading policy, Exhibit G, and demonstrating the actuarial soundness of the rates attached thereto.

Other policies which Applicant expects to sell initially are attached hereto, marked Exhibits I–1 and I–2. They are standard policies with no novel provisions.

VII

There is attached hereto, marked Exhibit J, a financial projection, based on reasonable and practicable assumptions as to volume of business expected to be transacted year by year, showing separately (1) all elements of income, (2) all elements of estimated expense, including reserves and premium taxes, and (3) unassigned surplus at the end of each year. Such projection assumes that 70 per cent of Applicant's business will be transacted on its leading policy, Exhibit G, and 15 per cent each on policy forms I–1 and I–2. There are separate exhibits attached hereto, marked Exhibits K and L, showing respectively the revenue expected to be developed under policies I—1 and I–2. Based on the actuarial results of the three policies from the business reasonably expected to be written, and adjusted for the volume to be written on each policy, the projection marked Exhibit J shows, at the end of the eighth year of production, that Applicant should make a small net gain from operations, excluding capital gains and losses. There will be no dividends to policyholders. Last said exhibit also shows that such net gain should increase during the ninth and tenth years of operation. It also shows that Applicant's net expenditure of surplus should not exceed $2,400,000 during its first eight years of operation and that it will, therefore, based on these estimates, be in a solvent condition at all times up to and including the end of its eighth year of operation, retaining its paid–in capital unimpaired at all times and at all times during the first five years of its operation having an unassigned surplus of not less than $500,000 and not less than $250,000 at all times after its first five years of operation. Such results are expected to be obtained without the sale of additional stock at any time during the period covered by said financial projection.

VIII

Attached hereto as Exhibit M are copies of the bids of three reinsurers, together with their sample contracts and an actuarial analysis of such bids. Applicant has tentatively elected to accept the reinsurance arrangements offered by XYZ Reinsurance Company. Its contract, if entered into, will embody the terms set forth in its sample contract included in Exhibit M.

IX

Applicant expects to sell stock through the personal solicitation of Applicant's President, Vice–President, and Agency Director, all of whom have had prior experience in selling insurance securities, as may be seen by reference to their biographies included in Exhibit C to this application. No commission will be paid to those individuals for selling the shares of Applicant's capital stock. Applicant's organizers, officers and original directors have executed an agreement conforming to Section 2613.08 I.S.P.R. whereby they agree to purchase 14,000 shares of applicant's capital stock for$700,000 cash, lawful money of the United States, before any shares are offered to the public. Said agreement, marked Exhibit N, is attached hereto and is by this reference incorporated herein and made a part hereof. It is expected that the remainder of Applicant's total stock offering of $4,000,000 will be purchased by members of the general public.

X

Applicant proposes to sell 80,000 shares of its $10.00 par value capital stock at a price of $50.00 per share. All expenses of incorporation, organization, promotion and stock selling, including, but not limited to governmental filing fees, legal fees, and actuarial fees from incorporation up to and including the obtaining of a certificate of authority from the Insurance Commissioner, if such certificate of authority is issued in response to due application therefor, will not exceed 10 per cent of the total amount paid for Applicant's capital stock. A detailed analysis of the expected fees, costs and expenses is attached hereto as Exhibit O.

XI

As of the date of this application, Applicant has no assets and no liabilities. A pro forma balance sheet showing Applicant's estimated paid–in capital, liabilities, unassigned surplus and surplus to policyholders as of the commencement of business is attached hereto as Exhibit P. Said balance sheet is compiled on the basis of the following assumptions: that the sale of Applicant's shares will be completed as planned; that Applicant will apply for and receive a certificate of authority; and that Applicant's Board of Directors will vote to pay, and the Treasurer will pay, all duly supported expense vouchers presented by the organizers and promoters.

XII

An originally signed letter of acceptance by ABC Bank and Trust Company of San Francisco agreeing to act as impound agent herein is attached hereto, marked Exhibit Q–1. A copy of said bank's agreement with applicant is marked Exhibit Q–2.

XIII

A draft of a prospectus which Applicant desires to use in the sale of its stock is attached hereto, marked Exhibit R. Applicant herewith submits the same for the Insurance Commissioner's authorization in the permit applied for. A copy of the proposed stock subscription form is attached hereto, marked Exhibit S. At the present time, Applicant does not plan to use any other written description of the stock proposed to be sold or any other written solicitation for the purchase thereof.

XIV

Attached hereto, marked Exhibits T–1 and T–2, are certified true copies of the minutes of the organizational meeting of Applicant's Board of Directors and of a special meeting of its Board authorizing the proposed stock sale and this application, respectively.

XV

Applicant expects to complete the sale of stock contemplated by this application in a period of six months from the date the permit is issued. No stock will be sold except within the state of California, and there will be no registration with the Securities and Exchange Commission.

* * *

WHEREFORE, Applicant respectfully requests that the Insurance Commissioner grant its application for a permit, extending six months from the date of issue thereof, authorizing Applicant to sell 14,000 shares of its capital stock to the persons described in Paragraph IX hereof, at $50 per share cash, and to sell not to exceed 66,000 shares of its $10.00 par value capital stock at a price of $50.00 per share, cash, lawful money of the United States, to the general public in this state; and requests that the proposed prospectus and the subscription form attached to this application be authorized for use by Applicant.

Dated at _____, California, this _____day of _____, 19_____.

ABC LIFE INSURANCE COMPANY

(Seal) By

_____ _____

Secretary President

(Verification as in Section 2603.10, supra)

§ 2613.05. Sample Form of Conditional Subscription for Stock (Without Cash Payment).

For convenient reference, see the following composite example of a form of subscription for stock to be used pursuant to a subscription permit.

CONDITIONAL SUBSCRIPTION FOR STOCK

TO: ABC Life Insurance Company
_____ Wilshire Boulevard
Los Angeles, California 90005

I hereby conditionally offer to purchase ____ shares of the $10 par value capital stock of ABC Life Insurance Company (hereinafter referred to as "Company") for the cash price of $50 per share upon the terms and under the conditions hereinafter set forth. Receipt of a copy of the California Insurance Commissioner's Subscription Permit No. _____, and a copy of this subscription agreement is herewith acknowledged.

It is agreed that the Company has the right to reject this offer, or, in its absolute discretion, to accept it for a number of shares less than the number above indicated.

It is understood that no certificate for shares or other security will be issued by ABC Life Insurance Company, nor will any consideration be collected on account of the shares herewith subscribed for, unless and until within one year from the date of the Subscription Permit Company shall have first applied for and duly obtained a definitive permit from the Insurance Commissioner. It is also understood that any such definitive permit will have additional requirements governing the issue of said shares including, among other things, the impounding of funds until a certificate of authority shall have been duly issued to Company by said Insurance Commissioner.

It is further understood that the shares herein applied for will be subject to all current regulations of the Insurance Commissioner. Those regulations include a requirement that the promoters, organizers, original directors and officers as a group shall purchase for cash at least 25% of the first $1,000,000 and 15% of all amounts of stock in excess of $1,000,000 (net of any commission) worth of stock offered; that such persons are required to execute an agreement providing that, with certain exceptions, for the periods hereinafter specified from and after issuance of a certificate of authority by the Insurance Commissioner (or completion of the original issue,whichever is later) they and each of them will not sell, transfer or encumber, except by operation of law, any shares acquired by them in satisfaction of said requirement or by exercise of promotional options without the Insurance Commissioner's written consent. Said agreement will permit each such person to dispose of the following amounts of the aggregate of said shares after elapsation of the following indicated periods: 5% after one year; an additional 5% after two years; an additional 10% after three years; an additional 20% after four years; and the remainder after five years.

Effectiveness of this subscription is expressly conditioned upon the promoters, organizers, original officers and directors purchasing shares in full compliance with the above mentioned requirement. However, upon the completion by them of such purchase, following the fulfillment of other conditions set forth herein, this subscription shall be irrevocable; whereupon, subscriber agrees to pay the purchase price in cash at Company's home office for shares subscribed to the extend accepted by company, within 30 days after Company's written request therefor subsequent to delivery to me of a copy of the (final)prospectus and the Insurance Commissioner's (definitive) permit and notification by Company that the promoters, organizers and original officers and directors have purchased and paid for their shares.

Provided always, that in the event the Insurance Commissioner's permit (receipt of a copy of which is acknowledged herein above) recites that no findings have as yet been made by him to the effect that sale and issuance of the securities thereby authorized to be subscribed for will be fair, just and equitable; and in the event the permit also specifies that each subscriber shall have an opportunity, within a reasonable time after receipt by him of a copy of the Insurance Commissioner's definitive permit and a copy of the prospectus approved by it, at the subscriber's election to disaffirm and cancel his subscription; —then, in such event, this subscription shall not become binding on me unless I shall receive (a) a copy of the Insurance Commissioner's permit containing such findings, (b) a copy of the prospectus approved by the last–mentioned permit, and (c) notification from Company that the organizers,promoters, original officers and directors have purchased and paid for their shares according to the conditions of said permit; and further, this subscription shall not become binding on me until, within twenty (20) days after receipt of items (a), (b) and (c) above, I shall have reaffirmed this subscription in writing and shall have actually communicated my reaffirmation to Company. In the event I do so, I hereby agree to pay in full as stated above, to the extent my subscription is accepted,within ten (10) days after Company's written request therefor.

Mail any further papers to me at _____

_____

_____

Dated _____, 19__

_____
Subscriber(s)

Accepted for _____ shares
ABC LIFE INSURANCE COMPANY
By _____
(Title)

§ 2613.06. Sample Form of Unconditional Subscription to Purchase Stock (With Cash Payment).

For convenient reference the following composite example of a form of subscription agreement for use under an organizational permit is provided. It is required that the substance of the last three paragraphs thereof be contained in any form of subscription agreement used where purchase money is collected and impounded.

SUBSCRIPTION TO PURCHASE STOCK OF A.B.C. INSURANCE COMPANY

I would like to purchase _____ shares of common capital stock of A.B.C. Insurance Company at $50.00 per share. The Stock Certificate should be registered as follows:

_____

_____

_____
Address

I hereby acknowledge receipt of a copy of Company's Prospectus dated _____, a copy of the Insurance Commissioner's Permit No. _____, and a copy of this subscription agreement.

Enclosed is my check (payable to A.B.C. Insurance Company) in the amount of $_____.

It is understood that the proceeds of my attached check or money order and all other stock purchase monies will be deposited in an impound with XYZ BANK, whose address is _____. In any event, the permit provides that stock purchase monies will not be impounded longer than one year without the consent of all subscribers.

Since there is a certain mutuality among subscribers, once a subscriber's deposit is made, it will not ordinarily be released from impound until the impound is terminated or the other subscribers consent to such release.

The impound will normally be terminated upon issuance of a certificate of authority to Company, whereupon all monies in impound will be paid over in full to Company and certificates for shares mailed to the purchasers. If the impound should be terminated for any other reason, stock purchase monies will be returned in full without interest to the subscribers, respectively, or in case of necessity to their successors in interest lawfully entitled thereto.

_____
Signature

_____

_____
Address

Received check for $_____
this _____ day of _____,199__.
A.B.C. INSURANCE COMPANY

_____
By _____
(Title or other description)

§ 2613.07. Biographical Affidavit Form.

The following affidavit will be required of the organizers, promoters,original officers and directors of all applicants for organizational permits, and may be required in the case of unseasoned applicants.

–oOo–

Permit_____
or Admission_____

Name of Company applying for Permit or Certificate of Authority:

_____

In connection with the application of the above named company to the California Insurance Commissioner for a permit or admission, I herewith make representations and supply information about myself as hereinafter set forth. I make these statements under oath. (Attach addenda on separate sheet if space hereon is insufficient to answer any question fully. If answer is "None" or "No exceptions," so state.

1. Affiant's Full Name: _____

2. Aliases used at any time: _____

3. Born _____ (Date) at _____(Place)

4. Color of Hair _____, Eyes_____, Height_____

5. Schooling (check those applicable)
High School _____
College _____
Graduate or _____
Professional _____
Degrees (list)_____

6. Member of Professional Societies or Associations. List: _____

7. I control directly or indirectly, or own legally or beneficially 10% or more of the outstanding capital stock (in voting power) of, the following insurers: _____

8. Present Chief Occupation.
Position or Title: _____
Employer:Name_____
Address_____
How long in this position?_____
How long with this employer?_____
Where? _____

9 .Other jobs, positions, directorates, or officership concurrently held at present:

10.Others held in the past: _____

11.If the answers to the foregoing do not show your *complete* experience *in or with the insurance industry,* detail the remainder on the back of this page. List names and addresses of insurance employers and positions held and approximate dates.

12. For the last 10 years, I have lived at the following address or addresses:

13. I have never been adjudicated a bankrupt, except as follows:

14. I have never been convicted or had a sentence imposed suspended or had pronouncement of a sentence suspended or been pardoned for conviction of, or pleaded guilty of or nole contendere to an information or an indictment charging a felony for embezzlement, theft or larceny, mail fraud, or violating any corporate securities statute or any insurance law, except as follows:

15. I presently hold or have held in the past the following professional, occupational and vocational licenses issued by public or governmental licensing agencies or authorities (state date license issued, issuer of license, date terminated, reason for termination) _____

16. During the last 10 years I have neither been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, nor has such a license held by me ever been suspended or revoked, except as follows: _____

17.I have never been named defendant in a suit brought by any public or governmental licensing agency or regulatory authority for violation of or to prevent the violation of any securities or insurance law, except as follows: _____

18. I have never been made the subject of a cease and desist order by any federal or state securities regulatory agency, except as follows: _____

19. I have never been an officer, director, trustee, investment committee member, key employee or controlling stockholder of an insurer which, while I occupied any such position or capacity with respect to it, became insolvent or was placed in conservatorship, or was enjoined from or ordered to cease and desist from violating any securities or insurance law, except as follows:

20. The certificate of authority or license to do business of any insurance company of which I was an officer or director or key management person has never been suspended or revoked while I occupied such position, except as follows:

21. No insurer of which I was an officer, director or key management person at the time has ever been denied or refused a license or certificate of authority or withdrawn an application therefor, except as follows:

22. (Complete for Permits only) The shares in the original issue (the subject of this organizational permit), subscribed for by me as a member of the group consisting of promoters, organizers, initial officers and directors, will be purchased with funds that are now, or will at the time of purchase be, my property, and no other person will have any legal or equitable interest in said shares, after purchase except as follows:

_____
(Signature of Affiant)

NOTE: If this is executed in a state other than California, it is to be sworn to before a Notary Public and his official certificate attached hereto. If executed in California, affiant shall certify to the truth of the statements contained hereon and attached hereto, by completing and subscribing to the following:

STATE OF CALIFORNIA }
COUNTY OF _____ } ss

I hereby certify under penalty of perjury that the foregoing statements are true and correct.

_____
(Signature of Affiant)

Insurance Code Section 717, 718, 843.

§ 2613.08. Agreement by Organizers, Promoters, Original Officers and Directors Restricting Transfer of Shares.

The following represents a composite, sample form of an agreement the nature of which has been approved by the Commissioner:

AGREEMENT RESTRICTING TRANSFER OF SHARES

This Agreement made and entered into this _____ day of _____, 199 __, by and between ABC LIFE INSURANCE COMPANY, a California corporation (hereinafter called "Company") and _____ (hereinafter called "Shareholder"),

WITNESSETH:

WHEREAS, Company has obtained a permit from the Insurance Commissioner of the state of California (hereinafter called "Commissioner"), being No, ____ issued _____, authorizing the sale and issuance of company's shares; and

WHEREAS, Condition _____ of said permit required the promoters, organizers and all original officers and directors of Company before any public offering and sale is made to purchase a certain number of the shares sought to be authorized and requires certain restrictions to be placed upon transfer of their said shares for varying periods of time; and

WHEREAS, Shareholder has purchase, or has agreed to purchase, from Company certain of its shares which will be subject to said restrictions, and the number of shares to be purchased and restricted is enumerated on an addendum attached hereto:

NOW, THEREFORE, the parties hereto agree as follows:

1. That, except as stated in Paragraph 2 hereof, Shareholder will not sell, transfer, or encumber any of the restricted shares without prior written consent of the Commissioner.

2. The exceptions referred to in Paragraph 1 above are as follows:

a. The following percentages to the nearest whole share of the restricted shares shall be released automatically from the restrictions set forth in this Agreement without further approval or consent by the Insurance Commissioner, or any other party, at the following respective times: 5% at the end of the first year of the 5-year restriction period; an additional 5% at the end of the second year; an additional 10% at the end of the third year; an additional 20% at the end of the fourth year; and the remainder at the end of the fifth year.

b. Any or all of the restricted shares may be transferred by Shareholder at any time by gift to the following described person or persons: Shareholder's spouse, child, or grandchildren; Shareholder or spouse's parent, brother, sister, or child of brother or sister. (It is understood that the singular includes the plural, and vice versa,in this Agreement.)

c. Any or all of the restricted shares may be transferred at any time by operation of law, pursuant to last will and testament of Shareholder, or pursuant to the laws of descent and distribution.

d. Any or all of the restricted shares may be transferred at any time with the prior written consent of the Commissioner, and Company hereby consents to such transfers. It is understood that among the reasons which may, but not necessarily will, cause the Commissioner to give such consent are the following:

(1) Significant change in the financial position or affairs of Shareholder, not within the control of Shareholder, that would otherwise result in hardship;

(2) Proposed pledging of any or all of the restricted shares as collateral for a loan to be made to shareholder;

(3) A transfer of any or all of the restricted shares by Shareholder to another Shareholder, some or all of whose shares are subject to the restrictions of this Agreement, or similar restrictions;

(4) The transfer of any or all of the restricted shares by Shareholder to a transferee having a sufficient financial sophistication and/or knowledge of the insurance industry and such insurance securities to satisfy the Commissioner that such transfer would be in the proper interest of Company, its policyholders and other shareholders. Any such transfer which would destroy or impair desirable leadership of the Company, or be conducive to internal dissension will be disfavored.

3. Any of the restricted shares which are transferred pursuant to the provisions of Paragraph 2 above, except shares automatically released from these (or similar) restrictions upon elapsation of the periods stated in subparagraph (a) of said Paragraph 2 above, and restricted shares transferred pursuant to last will and testament of Shareholder,or the laws of descent and distribution, shall continue to be subject to the provisions of this Agreement after such transfer, as if such transfer had not occurred.

4. Each certificate representing restricted shares shall bear the following legend until the shares represented by such certificate are released from the aforementioned restrictions: Not transferable except per Condition _____ of Insurance Commissioner's Permit No. ____, prior to _____."

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date and year first above written.

ABC LIFE INSURANCE COMPANY

By_____
Officer

_____
Shareholder

Subchapter 4.3. Procedures for Noncompliance Hearings

Article 1. Governing Procedure for Noncompliance Hearings

§ 2614. Definitions.

In this chapter unless the context or subject matter otherwise requires:

(a) "Department" means the California Department of Insurance.

(b) "Commissioner" means the Insurance Commissioner.

(c) "Enforcement action" means any action based upon an allegation by the Department that an insurer, organization, group or association, or any rate, rating plan, rating system, or underwriting rule does not comply with the requirements and standards of Chapter 9 of the California Insurance Code entitled Rates and Rating and Other Organizations.

(d) "Party" includes the Department, the respondent, intervenors, and any person, other than an officer or an employee of the Department in his or her official capacity, who has been allowed to appear or participate in the proceeding.

(e) "Respondent" means any person or entity against whom a Notice of Noncompliance is filed.

(f) "Intervenor" means any person or entity whose petition to intervene pursuant to California Insurance Code section 1861.10 has been granted.

(g) "Notice of noncompliance' means the administrative document issued by the Commissioner. A notice of noncompliance shall set forth in ordinary and concise language in what manner and to what extent noncompliance is alleged to exist.

(h) "Administrative Hearing Bureau" means that office, within the office of the Commissioner and, except where otherwise specified in this subchapter, designated for receipt of all pleadings filed pursuant to this subchapter.

(i) "Administrative law judge" means a judge in the Administrative Hearing Bureau within the office of the Commissioner.

(j) "Hearing Officer" means a person appointed by the Commissioner to conduct a noncompliance hearing.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New subchapter 4.3, article 1 (sections 2614–2614.27) and section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.1. Authority of Administrative Law Judge or Hearing Officer.

(a) To the extent not otherwise specified by law or regulation, the administrative law judge or hearing officer shall: control the course of proceedings; grant or deny requests for continuances; administer oaths; issue subpoenas; rule on motions to compel discovery; receive evidence; upon notice, hold appropriate conferences before or during hearings; rule upon all objections or motions which do not involve final determination of proceedings; receive offers of proof; hear argument; recommend to the Commissioner approval or disapproval of proposed stipulations and settlements; and fix the time and place for the filing of briefs.

(b) The administrative law judge or hearing officer shall eliminate unnecessary delay in the progress and ultimate resolution of the proceeding, assume and maintain control over the pace of the proceeding, actively manage the proceeding from commencement to disposition, and compel all parties to prepare and resolve all issues without delay. The administrative law judge or hearing officer shall discourage continuances, only granting continuances for good cause shown. Good cause includes circumstances such as serious illness of a participant in the proceeding, death in the family of a participant in the proceeding, or jury duty obligations of a participant in the proceeding.

(c) The chief administrative law judge shall exercise all authority set forth in this section until a proceeding is assigned to an administrative law judge or hearing officer.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.2. Commencement of Proceedings.

(a) An enforcement action is commenced when the Department serves a written notice of noncompliance pursuant to California Insurance Code section 1858.1, which shall state in what manner and to what extent noncompliance is alleged to exist; specifying a reasonable time, not less than 10 days thereafter, in which that noncompliance may be corrected; and specifying the amount of any penalty that may be due under Insurance Code section 1858.07.

(b) An administrative proceeding is commenced when the Department files a request for hearing pursuant to California Insurance Code section 1858.2 with the Administrative Hearing Bureau. The request for hearing shall include copies of any notice of noncompliance served on respondent by the Department and any written response thereto by respondent.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.3. Amended or Supplemental Notice of Noncompliance.

At any time before the matter is submitted for decision the Department may file an amended or supplemental notice of noncompliance. If the amended or supplemental notice of noncompliance presents new charges, respondent shall be afforded a reasonable opportunity to prepare a defense thereto, but respondent shall not be entitled to file a further pleading unless the administrative law judge or hearing officer in its discretion so orders. Any new charges shall be deemed controverted, and any objections to the amended or supplemental pleading shall be in writing.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.4. Consolidation and Bifurcation.

(a) When proceedings that involve a common question of law or fact are pending, the administrative law judge or hearing officer on the judge's or officer's own motion or on motion of a party may order a joint hearing of any or all the matters at issue in the proceedings. The administrative law judge or hearing officer may order all the proceedings consolidated and may make orders concerning the procedure that may tend to avoid unnecessary costs or delay.

(b) The administrative law judge or hearing officer, on the judge's or officer's own motion or on motion of a party, in furtherance of convenience or to avoid prejudice, or when separate hearings will be conducive to expedition and economy, may order a separate hearing of any issue.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.5. Continuances.

(a) When an administrative law judge or hearing officer has been assigned to a proceeding, no continuance may be granted except by him or her, and only for good cause shown.

(b) When seeking a continuance, a party shall apply for the continuance within 10 working days following the time the party discovered or reasonably should have discovered the event or occurrence that establishes the good cause for the continuance. A continuance may be granted for good cause after the 10 working days have elapsed if the party seeking the continuance is not responsible for and has made a good faith effort to prevent the condition or event establishing the good cause.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.6. Burden and Order of Proof.

(a) The Department or intervenor has the burden of proving, by a preponderance of the evidence, every fact necessary to show in what manner and to what extent noncompliance is alleged to exist.

(b) In addition to its burden of proof, the Department or intervenor shall have the burden of presenting its evidence and witnesses first.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.7. Discovery: Exclusive Provisions.

The provisions of Section 2614.8 provide the exclusive right to and method of discovery as to any proceeding governed by this chapter.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.8. Requests for Discovery.

(a) A party, upon written request made to another party, prior to the hearing and within 30 days after a request for hearing has been served, is entitled to obtain the names and addresses of witnesses to the extent known to the other party, including, but not limited to, those intended to be called to testify at the hearing; and inspect and make a copy of any of the following in the possession or custody or under the control of the other party:

(1) A statement pertaining to the subject matter of the proceeding made by any party to another party or person;

(2) statements of witnesses then proposed to be called by the party and of other persons having personal knowledge of the acts, omissions or events which are the basis for the proceeding, not included in (1) above;

(3) investigative reports made by or on behalf of the Department or other party pertaining to the subject matter of the proceeding, to the extent that these reports contain the names and addresses of witnesses or of persons having personal knowledge of the acts, omissions or events which are the basis for the proceeding; or reflect matters perceived by the investigator in the course of his or her investigation; or contain or include by attachment any statement or writing described in (1) or (2) or summary thereof;

(4) any other document or thing which is relevant and which would be admissible in evidence.

(b) For the purpose of this section, "documents" means a writing as defined in Evidence Code section 250 and "statements" includes written statements by the person signed or otherwise authenticated by him or her, stenographic, mechanical, electrical or other recordings, or transcripts thereof, of oral statements by the person, and written reports or summaries of these oral statements.

(c) The written response to any discovery request shall be served on the requesting party within fifteen (15) days of service of the discovery request. Upon mutual agreement of all parties and interveners: 1) written documents may be converted into another mutually agreeable format, such as electronic or magnetic, and made readily available, or 2) a depository of original items may be used in place of delivery of copies, but the depository shall be open beyond regular business hours upon request of a party or intervener. The parties shall have an ongoing duty to produce additional items pursuant to whichever method is agreed upon as new items become relevant.

(d) When a party withholds information otherwise discoverable by claiming it is privileged, that party shall make the claim expressly and shall describe the nature of the documents, communications, or things not produced or disclosed in a manner that, without revealing informa-

tion itself privileged or protected, will enable other parties to assess the applicability of the specifically asserted privilege or protection. Simultaneously, the withholding party shall also draft and provide a confidentiality agreement to the other parties and the administrative law judge or hearing officer if a confidentiality agreement can protect the interest in nondisclosure.

(e) If new information is discovered at any time during the course of the hearing, it shall be called to the attention of the administrative law judge or hearing officer immediately, who may grant discovery thereon if requested by a party. The administrative law judge or hearing officer shall specify the scope and timing of any such additional discovery.

(f) Nothing in this section shall require any party to disclose information contained in a document that is privileged from disclosure by law or otherwise made legally confidential or protected as an attorney's work product.

(g) Nothing in this section shall limit the Commissioner's investigatory powers as otherwise provided by statute including, but not limited to, Insurance Code Section 12924.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.9. Compelling Discovery.

(a) Any party claiming that a request for discovery has not been complied with shall, within five (5) business days of receipt of the responses, meet and confer with the party from whom discovery is sought to attempt to resolve the discovery dispute.

(b) Any party claiming that a request for discovery has not been complied with following the meet and confer session shall, within five (5) business days of the meet and confer session, file and serve a motion to compel discovery accompanied by a copy of the original discovery request and response thereto. The motion to compel discovery shall specify why the requested information is sought, and include facts showing a reasonable and good faith attempt at an informal resolution of each issue presented by the motion.

(c) The party from whom discovery is sought shall file and serve any additional response within five (5) business days of service of the motion. The administrative law judge or hearing officer shall set a hearing on the motion for a time within ten (10) business days after filing of the response or at a later time that the administrative law judge or hearing officer, on the judge's or officer's own motion, for good cause determines. At or before the commencement of the hearing, the administrative law judge or hearing officer shall inform the parties of his or her tentative ruling on the motion. The administrative law judge or hearing officer shall issue a decision on the motion to compel discovery within five (5) business days of the date of the hearing on the motion to compel discovery.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.10. Prehearing Conference.

(a) On motion of a party or by order of an administrative law judge or hearing officer, the administrative law judge or hearing officer may conduct one or more prehearing conferences. The administrative law judge or hearing officer shall set the times and places for the prehearing conferences, and shall give reasonable written notice to all parties.

(b) The prehearing conferences may address one or more of the following matters:

(1) Exploration of settlement possibilities.

(2) Preparation of stipulations.

(3) Clarification of issues.

(4) Rulings on identity and limitation of the number of witnesses.

(5) Objections to proffers of evidence.

(6) Order of presentation of evidence and cross–examination.

(7) Rulings regarding issuance of subpoenas and protective orders.

(8) Schedules for the submission of written briefs and schedules for the commencement and conduct of the hearing.

(9) Exchange of witness lists and of exhibits or documents to be offered in evidence at the hearing.

(10) Motions for intervention.

(11) Any other matters as shall promote the orderly and prompt conduct of the hearing.

(c) The administrative law judge or hearing officer may conduct all or part of a prehearing conference by telephone or other electronic means if each participant in the conference has an opportunity to participate in and to hear the entire proceeding while it is taking place.

(d) The administrative law judge or hearing officer shall issue a prehearing order incorporating the matters determined at the prehearing conferences. The administrative law judge or hearing officer may direct one or more of the parties to prepare a prehearing order.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.11. Exchange of Witness Lists.

(a) Upon a date agreed upon by all parties or ordered by the administrative law judge or hearing officer, all parties who have appeared in the action shall exchange information concerning witnesses. The exchange of information may occur at a meeting of the attorneys for the parties involved or by a mailing on an agreed upon date.

(b) The exchange of witness information shall include the following:

(1) A list setting forth the name of any person who will be offering testimony.

(2) A brief narrative statement of the general substance of the testimony that each witness is expected to give.

(3) A brief narrative statement of the qualifications of each expert witness.

(4) All discoverable reports and writings, if any, made by each expert witness.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.12. Supplemental Witness List Exchange.

Within 30 days after the exchange described in 2614.11, any party who engaged in the exchange may submit a supplemental witness list containing the name of any witness who will provide testimony on a subject to be covered by a witness designated by an adverse party to the exchange, if the party supplementing a witness list has not previously designated a witness to testify on that subject, and shall include all discoverable reports and writings, if any, made by each additional designated expert witness.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.13. Prepared Testimony.

(a) Prepared direct testimony, in narrative statement or question and answer format, of each direct witness expected to be called to testify by the Department or intervenor or participant in a proceeding, shall be filed and served on all parties at least forty (40) business days before the first day of the evidentiary hearing. Prepared direct testimony, in narrative statement or question and answer format, of each direct witness expected to be called to testify in a proceeding by respondent, shall be filed and served on all parties no later than twenty (20) business days after service of the prepared direct testimony by the Department or intervenor or participant. Prepared direct testimony shall be signed under penalty of perjury under the laws of the state of California. Expert witness testimony shall be accompanied by the witnesses' curriculum vitae and list of authored or co–authored publications. Additionally, any documents reviewed by the expert for purposes of testifying in the specific case that were not pre-

viously provided to the other parties shall be produced with the testimony.

(b) Within ten (10) business days of service of any prepared direct testimony, any party may file a motion to strike all or part of the testimony and object to admission of exhibits referenced in such testimony. The motion shall state the specific page(s) and line(s) to which the party is objecting, and the specific legal authority for the objection. Within five (5) business days of service of a motion to strike, the party filing the prepared direct testimony may respond to the motion to strike. A hearing on any motion to strike shall be held within five (5) business days of service of any response to the motion to strike. At or before the commencement of the hearing on the motion to strike, the administrative law judge or hearing officer shall inform the parties of his or her tentative ruling on the motion. The administrative law judge or hearing officer shall rule on the motion to strike no later than three (3) business days after the hearing on the motion to strike. Any testimony not objected to and any testimony not stricken, together with exhibits referenced in that testimony, shall be deemed admitted.

(c) If rebuttal prepared testimony is allowed, motions to strike may be made orally and ruled upon immediately in order to expedite the proceeding.

(d) At the evidentiary hearing, the person whose prepared testimony is being offered shall be available for cross-examination by all parties.

(e) Prepared testimony of more than twenty (20) pages shall contain a subject index.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12-20-2006; operative 1-19-2007 (Register 2006, No. 51).

§ 2614.14. Additional Direct Testimony.

Prior to his or her cross-examination, any witness may provide additional direct testimony responding to testimony elicited of any other witness. Any additional direct testimony which is likely to take more than one hour of hearing time to present shall meet all requirements applicable to direct testimony, shall be in the format specified in section 2614.13, and shall be filed and served on all parties at least two (2) business days before the witness is called to testify.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12-20-2006; operative 1-19-2007 (Register 2006, No. 51).

§ 2614.15. Rebuttal Testimony.

At the conclusion of the direct presentations of all parties, the parties may file written rebuttal testimony or provide oral rebuttal testimony. Rebuttal testimony shall be subject to cross examination as provided in section 2614.13(d). The rebuttal testimony shall meet all requirements applicable to direct testimony, and shall be in the format specified in section 2614.13 and if in written format shall be filed and served on all parties at least two (2) business days before the rebuttal witness is called to testify. The rebuttal testimony shall only respond to testimony of another party or witness.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12-20-2006; operative 1-19-2007 (Register 2006, No. 51).

§ 2614.16. Exhibits.

(a) Any exhibit that a party wishes to be part of the evidentiary record of this proceeding shall be lodged with the administrative hearing bureau and served on all other parties in the manner and by the date directed by the administrative law judge or hearing officer.

(b) A party offering a document in excess of ten (10) pages shall designate specifically the relevant and material portions, and shall provide a copy of the entire document to every other party prior to the offer in evidence. The other parties shall be provided five (5) business days to examine the document, from the date of receipt of the document, and to offer in evidence other relevant and material portions of the document.

(c) Exhibits shall be legible and whenever practicable either prepared on paper not exceeding 8-1/2 inches wide and 11 inches long, or bound or folded to that approximate size. Exhibits may be created during the hearing, but shall be recreated for the record on paper not exceeding 8-1/2 inches wide and 11 inches long. Wherever practicable, the sheets of each exhibit shall be numbered. Copies of exhibits shall be clear and legible.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12-20-2006; operative 1-19-2007 (Register 2006, No. 51).

§ 2614.17. Oral Evidence.

(a) Oral testimony shall be taken only on oath or affirmation.

(b) Each party shall have these rights: to call and examine witnesses; to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence against him or her. If respondent does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

(c) The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided.

(d) Hearsay evidence may be used to supplement or explain other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case.

(e) The rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the hearing.

(f) The administrative law judge or hearing officer has discretion to limit oral testimony and to exclude evidence if its probative value is substantially outweighed by the probability that its admission will necessitate undue consumption of time.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12-20-2006; operative 1-19-2007 (Register 2006, No. 51).

§ 2614.18. Official Notice.

In reaching a decision, official notice may be taken, either before or after submission of the case for decision, of any generally accepted technical or scientific matter within the Department's special field, and of any fact that may be judicially noticed by the courts of this State. Parties present at the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto. Any such party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the administrative law judge or hearing officer.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12-20-2006; operative 1-19-2007 (Register 2006, No. 51).

§ 2614.19. Settlement Conferences.

(a) The administrative law judge or hearing officer may order the parties to attend and participate in a settlement conference. The chief administrative law judge shall assign an administrative law judge or hearing officer to conduct the settlement conference, other than the administrative law judge or hearing officer assigned to the case; set the time and place for the settlement conference; and give reasonable written notice to all parties.

(b) The administrative law judge or hearing officer assigned to conduct the settlement conference may conduct all or part of the settlement conference by telephone or other electronic means if each participant in the conference has an opportunity to participate in and to hear the entire proceeding while it is taking place.

(c) Discussions, admissions, concessions, or offers to stipulate or settle, whether oral or written, made during any negotiation or settlement conference are confidential and inadmissible for any purpose in any proceeding.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.20. Stipulations and Settlements.

(a) Parties may stipulate to the resolution of an issue of fact or the applicability of a provision of law material to a proceeding or may agree to settlement on a mutually acceptable outcome to a proceeding, with or without resolving material issues.

(b) If the parties agree to settlement on a mutually acceptable outcome to a proceeding, with or without resolving material issues, they shall obtain an order approving their settlement from the Commissioner. Immediately following the Commissioner's approval of a settlement, the parties shall file a signed request to withdraw their request for hearing with the Administrative Hearing Bureau.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.21. Additional Evidence.

(a) The administrative law judge or hearing officer may require the production of further evidence on any issue until the record is closed. If the administrative law judge or hearing officer determines that specific documentary evidence is necessary as a part of the record, the administrative law judge or hearing officer shall set a deadline for filing, reserving exhibit numbers therefor. Copies of all documents produced shall be served on all parties.

(b) If the administrative law judge or hearing officer requires the production of further evidence, that evidence shall be provided no later than ten (10) days from the date the administrative law judge notifies the party from whom the evidence is sought that additional evidence is required.

(c) Any objections to admitting the evidence produced upon the order of the administrative law judge or hearing officer shall be filed no later than five (5) days after the evidence is served.

(d) Unless ordered by the administrative law judge or hearing officer, evidence other than matters that can be officially noticed shall not be provided after the close of the evidentiary hearing.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.22. Submission of Proceeding.

A proceeding shall stand submitted when the record is closed by the administrative law judge or hearing officer.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.23. Amendment to Notice of Noncompliance After Submission of Case for Decision.

The Department may request leave to amend the notice of noncompliance to conform to proof, after submission of the case for decision. Each party shall be given notice of the intended amendment and opportunity to show that it will be prejudiced thereby unless the case is reopened to permit the introduction of evidence on the party's behalf. If such prejudice is shown, the ALJ may either deny leave to amend or reopen the case to permit introduction of additional evidence.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.24. Proposed Decision.

(a) The administrative law judge or hearing officer shall prepare within 60 days after the record is closed a proposed decision in a form that may be adopted by the Commissioner as the final decision in the case. Failure of the administrative law judge or hearing officer to deliver a proposed decision within the time required does not prejudice the rights of the Commissioner in the case.

(b) Within 100 days of receipt by the Commissioner of the administrative law judge's proposed decision, the Commissioner may act as prescribed in subparagraphs (b)(1) to (5), inclusive. If the Commissioner fails to act as prescribed in subparagraphs (b)(1) to (5), inclusive, within 100 days of receipt of the proposed decision, the proposed decision shall be deemed adopted by the Commissioner. The Commissioner may do any of the following:

(1) Adopt the proposed decision in its entirety.

(2) Reduce or otherwise mitigate the proposed penalty and adopt the balance of the proposed decision.

(3) Make technical or other minor changes in the proposed decision and adopt it as the decision. Action by the Commissioner under this paragraph is limited to a clarifying change or a change of a similar nature that does not affect the factual or legal basis of the proposed decision.

(4) Reject the proposed decision and refer the case to the same administrative law judge or hearing officer if reasonably available, otherwise to another administrative law judge or hearing officer, to take additional evidence. If the case is referred to an administrative law judge or hearing officer pursuant to this subparagraph, he or she shall prepare a revised proposed decision based upon the additional evidence and the transcript and other papers that are part of the record of the prior hearing. A copy of the revised proposed decision shall be furnished to each party or his or her attorney as prescribed in subparagraph (c).

(5) Reject the proposed decision, and decide the case upon the record, including the transcript, or upon an agreed statement of the parties, with or without taking additional evidence.

(c) The decision of the Commissioner shall be filed immediately by the Department as a public record and a copy shall be served on each party or the party's attorney.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1, 1858.2 and 1858.3, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.25. Petition for Reconsideration.

(a) Within 15 days after service of a copy of the decision on a party, but not later than the effective date of the decision, a party may apply to the Commissioner for correction of a mistake or clerical error in the decision, stating the specific ground on which the application is made. Notice of the application shall be served on the other parties to the proceeding, with a copy filed with the Administrative Hearing Bureau. The application is not a prerequisite for seeking judicial review.

(b) The Commissioner may deny the application, grant the application and modify the decision, or grant the application and set the matter for further proceedings. The application is considered denied if the Commissioner does not dispose of it within 15 days after it is made.

(c) Nothing in this section precludes the Commissioner from modifying the decision to correct a mistake or clerical error. A modification under this subdivision shall be made within 15 days after issuance of the decision.

(d) The Commissioner shall, within 15 days after correction of a mistake or clerical error in the decision, serve a copy of the correction on each party on which a copy of the decision was previously served.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.26. Effective Date of Decision.

(a) The decision shall become effective 30 days after it is delivered or mailed to the parties unless: reconsideration is ordered within that time,

or the administrative law judge or hearing officer or Commissioner orders that the decision shall become effective sooner.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

§ 2614.27. Default Proceedings.

(a) If a respondent fails to appear at the hearing, the administrative law judge or hearing officer may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

(b) Notwithstanding the default of the respondent, the administrative law judge or hearing officer, before a proposed decision is issued, has the discretion to grant a hearing on reasonable notice to the parties. The administrative law judge or hearing officer may order the respondent, or the respondent's attorney or other authorized representative, or both, to pay reasonable expenses, including attorney's fees, incurred by another party as a result of the respondent's failure to appear at the hearing.

(c) Within seven days after service on the respondent of a decision based on the respondent's default, the respondent may serve a written motion requesting that the decision be vacated and stating the grounds relied on. The administrative law judge or hearing officer may vacate the decision and grant a hearing on a showing of good cause. As used in this subdivision, good cause includes, but is not limited to, any of the following: mistake, inadvertence, surprise, or excusable neglect.

NOTE: Authority cited: Section 11400.20, Government Code. Reference: Sections 1858, 1858.01, 1858.1 and 1858.2, Insurance Code.

HISTORY

1. New section filed 12–20–2006; operative 1–19–2007 (Register 2006, No. 51).

Subchapter 4.5. General Provisions

Article 1. Governing Procedure for Hearings

§ 2615. Authority.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Section 11400.20 of the Government Code.

NOTE: Authority cited: Sections 11400.20 and 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. Change without regulatory effect amending subchapter and article headings, renumbering former subchapter 11, article 1 (sections 2698.99.10–2698.99.13) to subchapter 4.5, article 1 (sections 2615–2615.3) and renumbering section 2698.99.10 to section 2615 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2615.1. Purpose.

The purpose of these regulations is to provide a general governing procedure for Department of Insurance adjudicative hearings. However, when other regulations set forth a procedure for an adjudicative hearing explicitly provided for in the Insurance Code, the regulations implementing the specific Insurance Code provision will govern. Additionally, these regulations do not apply to those adjudicative hearings that, by statute, are subject to the provisions of Chapter 5 of the Government Code.

NOTE: Authority cited: Section 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. Change without regulatory effect renumbering section 2698.99.11 to section 2615.1 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23). For prior history of section 2615.1, see Register 96, No. 45.

§ 2615.2. Governing Procedure: Requirements.

All Department of Insurance adjudicative hearings not governed by other procedural regulations shall allow the use of both written and live witness testimony, subject to motions to strike and cross–examination. However, the presiding officer shall have the authority to limit the length and repetitiveness of all testimony, and to control the order and manner of presentation of witnesses.

NOTE: Authority cited: Section 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. Change without regulatory effect renumbering section 2698.99.12 to section 2615.2 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2615.3. Governing Procedure: Pre–Hearing Order.

In addition to the procedures set forth and referenced in § 2615.2, the presiding officer shall have the authority to prescribe the procedure for an adjudicative hearing more specifically in a Pre–Hearing Order. Scheduling, allowable pleadings and motions, use of discovery, if any, scope of relevant evidence, rebuttal rights, if any, briefing, if any, and all other procedural matters may be addressed in a pre–hearing order.

NOTE: Authority cited: Section 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. Change without regulatory effect renumbering section 2698.99.13 to section 2615.3 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).
2. Change without regulatory effect amending section filed 8–12–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 33).

Article 2. Definitions

§ 2616.1. Definitions.

NOTE: Authority cited: Sections 1861.055, 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 791.15, 12096 and 1861.10(a), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Renumbering and amendment of former section 2616.1 to new section 2661.1 filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Renumbering and amendment of former section 2616.1 to new section 2661.1 refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Renumbering and amendment of former section 2616.1 to new section 2661.1 filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

Article 3. Intervention in Quasi–Judicial Proceedings

§ 2617.1. Intervention Under Chapter 9 of Part 2 of Division 1 of the California Insurance Code.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(a), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2617.2. Other Intervention.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 791.15, 1861.10(b), 12096 and 12925, Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2617.3. Procedure for Intervention.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 791.15, 1861.10(a), 12096, 12921.5 and 12925, Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Renumbering and amendment of former section 2617.3 to new section 2661.3 filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Renumbering and amendment of former section 2617.3 to new section 2661.3 refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2617.4. Rights and Duties of Intervenors.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 791.15, 1861.10(a), 12096, 1292.5 and 12925, Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2617.5. Participation Without Intervention.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 791.15, 838.5, 12096, 12921.5 and 12925, Insurance Code.

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2617.6. Service.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2617.7. Certificate of Service.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register

[The next page is 703.]

90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2617.8. Filing Office.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2617.9. Submission of Pleadings.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b),(c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 4. Participation in Quasi-Legislative Proceedings

§ 2618.1. Adopting, Amending or Repealing a Regulation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 11340 et seq., Government Code.

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2618.2. Title and File Number.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court, No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.3. Signatures.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm*

Insurance Company, et al. v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.4. Verification.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.5. Signature and Verification by Attorney.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.6. Service of Filings.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.7. Copies.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08, 1861.10(a) and 12979, Insurance Code; Section 6256, Government Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.8. Amended Pleadings.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39)

§ 2618.9. Form of Application.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.05(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989 Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Editorial correction to Graphic (Register 91, No. 17).
9. Request to readopt section including editorial correction of form CA–R2 on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
10. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.10. Place of Filing.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), 1861.07, 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Regis-

ter 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.11. Time of Filing.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance will be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.12. Rejection of Documents.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.13. Acknowledgments.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), Insurance Code; *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989 Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.14. Computation of Time.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), 1861.08 and 1861.10(c), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989 Supreme Court No. S007838, pp. 24–25, Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register

90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.16. List of Filings.

NOTE: Authority cited: Sections 12921, 12926 and 12973.7, Insurance Code. Reference: Sections 1861.05(c), 1861.06, 1861.07 and 12973.7, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2618.17. Public Inspection.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.07, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 5. Eligibility for Compensation

§ 2619.1. Request for Eligibility to Seek Compensation.

NOTE: Authority cited: Sections 1861.10 and 12921, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer of article 5 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer of article 5 and section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of appeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer of article 5 and section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency langauge will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2619.2. Finding of Eligibility to Receive Compensation.

NOTE: Authority cited: Sections 1861.10 and 12921, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2619.3. Time Limitations.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2619.4. Service of Petition.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c) and 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2619.5. Time for Answer.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.05(c), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2619.6. Contents of Answer.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c) and 1861.08, Insurance Code; Section 11506, Government Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 6. Compensation in Other Quasi-Judicial Proceedings

§ 2620.1. Purpose.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.2. Notice of Intent to Claim Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Renumbering of former section 2620.2 to new section 2621.10—Appendix A filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day. The text of former section 2620.2 is incorporated by reference only for the purposes of subchapter 4.5, article 7.
3. Repealer filed 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3.
5. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
6. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.3. Response.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.4. Preliminary Determination.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.5. Request for Interim Funding.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.6. Awards of Interim Funding.

NOTE: Authority cited: Sections 1861.10 and 12921, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.7. Request for Final Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).

5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.8. Order for Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Renumbering of former section 2620.8 to new section 2621.10—Appendix A filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day. The text of former section 2620.8 is incorporated by reference only for the purposes of subchapter 4.5, article 7.
3. Repealer filed 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3.
5. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
6. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.9. Petition for Rehearing.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.10. Payment of Compensation.

NOTE: Authority cited: Sections 1859.1, 1861.05, 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989); and sections 685.010 and 917.1(b), Code of Civil Procedure.

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
5. Repealer filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2620.11. Awards for Judicial Proceedings.

(a) A party seeking compensation for work performed in judicial proceedings shall also apply for attorneys' fees and other costs of litigation available under statutory and common law provisions for attorneys' fees and costs. Any award received pursuant to such an application shall be used to reimburse the Department for compensation paid pursuant to these regulations.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Renumbering of former section 2620.11 to new section 2621.10—Appendix A filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day. The text of former section 2620.11 is incorporated by reference only for the purposes of subchapter 4.5, article 7.
3. Editorial correction deleting erroneous HISTORY.
4. Reinstatement of section as it existed prior to emergency renumbering filed 8–18–95 by operation of Government Code Section 11346.1(f) (Register 96, No. 22).

Article 7. Compensation in Quasi–Legislative Proceedings

§ 2621.1. Purpose.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer of article 7 and section filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.2. Notice of Intent to Claim Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.3. Preliminary Determination of Eligibility to Receive Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No 39.
2. Amendment of subsection (a) filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction deleting erroneous HISTORY.
4. Reinstatement of section as it existed prior to emergency amendment filed 8–18–95 by operation of Government Code section 11346.1(f) (Register 96, No. 22).
5. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.4. Request for Interim Funding.

NOTE: Authority cited: Sections 1861.10, 12921, 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal. 3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No 39.
2. Amendment of subsections (a) and (d) filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction deleting erroneous HISTORY.
4. Reinstatement of section as it existed prior to emergency amendment filed 8–18–95 by operation of Government Code section 11346.1(f) (Register 96, No. 22).

5. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.5. Awards of Interim Funding.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.6. Request for Final Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Amendment of subsections (a)(3) and (b) filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction deleting erroneous HISTORY.
4. Reinstatement of section as it existed prior to emergency amendment filed 8–18–95 by operation of Government Code section 11346.1(f) (Register 96, No. 22).
5. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.7. Order for Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Amendment of subsection (c) filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction deleting erroneous HISTORY.
4. Reinstatement of section as it existed prior to emergency amendment filed 8–18–95 by operation of Government Code section 11346.1(f) (Register 96, No. 22).
5. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.8. Petition for Rehearing.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Amendment of subsection (a) filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction deleting erroneous HISTORY.
4. Reinstatement of section as it existed prior to emergency amendment filed 8–18–95 by operation of Government Code section 11346.1(f) (Register 96, No. 22).
5. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.9. Payment of Compensation.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2621.10. Awards for Judicial Proceedings.

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).
2. New Appendix A to Article 7 filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day. The text of former sections 2620.2, 2620.8 and 2620.11 is incorporated by reference only for the purposes of subchapter 4.5, article 7.
3. Editorial correction deleting erroneous HISTORY.
4. Appendix A repealed by operation of Government Code section 11346.1(g) (Register 96, No. 22).
5. Repealer of section and appendix filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

Article 8. Public Advisor

§ 2622.1. Purpose

NOTE: Authority cited: Sections 1861.10, 12903, 12921 and 12921.3, Insurance Code; and section 11152, Government Code. Reference: Sections 12921.3 and 12921.5, Insurance Code.

HISTORY

1. New Article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer of article 8 and section filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2622.2. Overall Duty of the Public Advisor.

NOTE: Authority cited: Sections 1861.055, 1861.10, 12903, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 1858, 1861.10, 12921.3 and 12921.5, Insurance Code.

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2622.3. The Public Advisor's Duty to Refrain from Advocating Substantive Positions.

NOTE: Authority cited: Sections 12903, 12921 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 12921.3 and 12921.5, Insurance Code.

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2622.4. The Public Advisor's Duty within the Department of Insurance.

NOTE: Authority cited: Sections 1858, 1861.10, 12903, 12921, 12921.3 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 1858, 1861.10, 12921.3 and 12921.5, Insurance Code.

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

§ 2622.5. The Public Advisor's Duties in Advising Members of the Public.

NOTE: Authority cited: Sections 1858, 1861.055, 1861.06, 1861.10, 12921, 12921.3 and 12926, Insurance Code; and section 11152, Government Code. Reference: Sections 1861.10(a), 1861.10(b), 12921.3 and 12921.5, Insurance Code.

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.
2. Repealer filed 11–5–96; operative 11–5–96 (Register 96, No. 45).

Article 9. Forms

§ 2623.1. Petition to Intervene

Name
Address
Telephone Number of Petitioner or Attorney

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of Insurance Company, Applicant (or Respondent).	No. PETITION TO INTERVENE

_____ hereby petitions the Insurance Commissioner to intervene in this proceeding and in support of its petition alleges:

I

Petitioner is _____ (describe the status of petitioner.) _____.

II

The position and interest of petitioner in this proceeding is _____.

III

The grounds for petitioner's proposed intervention are _____.

IV

Petitioner's position is in support of (or in opposition to) the action sought by _____Insurance Company in this proceeding in that _____.

Wherefore, petitioner requests that the Insurance Commissioner allow petitioner to intervene in this proceeding, having all rights and responsibilities accorded any other party to the proceeding.

DATED:

Respectfully Submitted,

_____
Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Section 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY
1. New article and section filed 2–1–93; operative 2–1–93 (Register 93, No. 6). For prior history, see Register 92, No. 39.

[The next page is 714.3.]

§ 2623.2. Request for Finding of Eligibility to Seek Compensation.

Name
Address
Telephone Number of Petitioner or Attorney

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of Insurance Company, Applicant (or Respondent).	REQUEST FOR FINDING OF ELIGIBILITY TO SEEK COMPENSATION

_____ hereby requests that the Insurance Commissioner find it eligible to seek compensation in Departmental proceedings. In support of its request, _____alleges:

I

_____ represents a consumer interest not otherwise adequately represented, representation of which is necessary for a fair determination of the proceeding because _____ .

II

The individuals policyholder's economic interest or the economic interest of the members represented by a group or organization is small in comparison to the cost of effective participation because _____.

III

The other interests Petitioner represents are as follows (or) Petitioner represents no other interests.

Wherefore, _____ requests that the Insurance Commissioner find it eligible to seek compensation in Departmental proceedings based on this petition and the attached exhibits.

DATED:

Respectfully Submitted,

_____
Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Section 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY
1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.3. Notice of Intent to Seek Compensation.

Name
Address
Telephone Number of Petitioner or Attorney

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of Insurance Company, Applicant (or Respondent).	Case No. NOTICE OF INTENT TO SEEK COMPENSATION

I

Petitioner _____ intends to seek compensation in the above hearing.

II

Petitioner _____ represents the interest of the following individual consumers (describe) _____ and/or consumer group(s) (describe) _____.

III

Petitioner _____ represents no other interest (or) the other interest Petitioner represents is as follows: _____ (describe) _____.

IV

Petitioner _____ represents a consumer interest not otherwise adequately represented, representation of which is necessary for a fair determination of the proceeding because _____ _____ _____.

V

The issues Petitioner _____ intends to raise and the position of Petitioner on each issue is as follows:
_____
_____
_____.

VI

Petitioner _____ estimated budget is attached and is summarized as follows: _____
_____ _____
_____ _____
.

Wherefore, Petitioner _____ requests that the Insurance Commissioner issue a _____ determination _____ its budget based on the Notice and the attached exhibits.

DATED:

Respectfully Submitted,

_____
Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Section 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY
1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.4. Request for Interim Funding.

Name
Address
Telephone Number of Petitioner or Attorney

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of Insurance Company, Applicant (or Respondent).	Case No. REQUEST FOR INTERIM FUNDING

Petitioner _____ hereby request Interim Funding in the above matter.

I

On (date) _____ Petitioner became a party (or) participant (whichever is appropriate) in the above hearing.

II

On (date) _____ The Commissioner issued a Preliminary Determination of Eligibility to Receive Compensation in this matter.

III

Petitioner _____ has substantially contributed to the proceeding to date in that (describe contribution)

_____
_____.

IV

A detailed description of the work performed and its relevance to the proceedings is as follows: (cite to the record) _____
_____
_____.

V

A detailed description of services and expenditures of _____ in this proceeding are attached and made a part of this petition and is summarized as follows:

VI

WHEREFORE, Petitioner requests that the Commissioner issue an order awarding interim funding found in this Petition and the attached exhibits.

VII

But for the ability to receive interim funding Petitioner continued participation in the proceeding would be jeopardized because:

_____

_____.

DATED:

Respectfully Submitted,

_____

Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Section 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.5. Request for Award of Compensation.

Name
Address
Telephone Number of Petitioner or Attorney

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of Insurance Company, Applicant (or Respondent).	Case No. REQUEST FOR AWARD OF COMPENSATION

_____ hereby requests an award of compensation in the amount of _____ for its contribution in this proceeding. In the support of its request, _____alleges:

I

On_____(date)_____, (name of petitioner) was found eligible by the Insurance Commissioner to seek an award of compensation in Departmental proceedings.

II

On _____(date)_____, (name of petitioner) filed a Notice of Intent to Seek Compensation in this matter.

III

On _____(date)_____, the Commissioner issued a preliminary determination finding that _____
_____
_____.

(and)

(if applicable)

On _____(date)_____, Petitioner was given an interim award of _____ and _____ in this proceeding.

IV

A final decision by the Insurance Commissioner was issued in this proceeding on _____. This request is timely because it is submitted within 30 days of that day.

V

_____ substantially contributed to the Insurance Commissioner's final decision in that _____
_____.

VI

A detailed description of the services and expenditures of _____ in this proceeding are attached and made a part of this Petition and are summarized as follows:

reasonable advocacy fees of:
_____
_____
_.

reasonable witness fees of:
_____
_____
.

other reasonable expenses of:
_____
VII
_____
.

The amounts set forth in paragraph VI above are reasonable because
_____
_____
.

III

On _____ (date) _____, the Commissioner issued a preliminary determination finding that
_____
_____
_.

VIII

_____' s presentation did not materially duplicate the contribution or presentation of any other party to the proceeding in that _____.

IX
(If applicable)

Petitioner certifies that it has filed a request for attorney fees under the appropriate statutes in Civil Court (attach a copy).

WHEREFORE, _____ respectfully requests an award of compensation in the amount of _____ in this proceeding.

DATED:

Respectfully Submitted,

_____
Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Section 1861.10(a), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY
1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.6. Verification (for Corporation).

I am an officer of the applicant corporation herein, and am authorized to make this verification on its behalf. The statements in the foregoing document are true of my own knowledge, except as to the matters which are therein stated on information and belief, and as to those matters I believe them to be true.

I declare under penalty of perjury under California law that the foregoing is true and correct.

Executed on _____ (date) _____ at _____ (name of city), California.

DATED:

Respectfully Submitted,

_____

Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b) and (c), 1861.08 and 1861.10(a), (b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.7. Verification Where Applicant is Absent from County of Attorney's Office.

I am the attorney for the applicant herein who is absent from the County of _____, California, where I have my office, and I make this verification for the applicant for that reason; the statements in the foregoing documents are true of my own knowledge except as to the matters which are therein stated on information or belief, and as to those matters I believe them to be true.

I declare under penalty of perjury under California law that the foregoing is true and correct.

Executed on _____(date)_____ at _____(name of city), California.

DATED:

Respectfully Submitted,

_____
Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b), (c), 1861.08 and 1861.10(a), (b), Insurance Code and; *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY
1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.8. Verification (for Individuals or Partnerships).

I am (one of) the _____s in this matter; the statements in the foregoing document are true of my knowledge, except as to matters which are therein stated on information and belief, and as to those matters, I believe them to be true.

I declare under penalty of perjury under California law that the foregoing is true and correct.

Executed on _____(date)_____ at _____(name of city), California.

DATED:

Respectfully Submitted,

_____
Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b) and (c), 1861.08 and 1861.10(a) and (b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY
1. New section filed 2–1–93; operative 2–1–93 (Register 93, No. 6).

§ 2623.9. Certificate of Service by Mail.

I, _____ hereby declare:

I am over the age of 18 and not a party to this action. My business address is _____.

On _____(date)_____, I served a true and correct copy of the following document(s):

(list names of documents served)

_____

to all parties in this action by depositing in the United States mail, with proper postage prepaid, a sealed envelope containing a true copy of the above-named document(s), addressed to the last known address of each addressee as reflected on the attached service list.

I declare under penalty of perjury under California law that the foregoing is true and correct.

Executed on _____(date)_____ at _____(name of city)_____, California.

DATED:

Respectfully Submitted,

_____

Signature

NOTE: Authority cited: Sections 1861.10, 12921 and 12926, Insurance Code. Reference: Sections 1861.05(b) and (c), 1861.08 and 1861.10(a), (b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 2-1-93; operative 2-1-93 (Register 93, No. 6).

Article 10. Motions to Dismiss

§ 2624.1. Time for Filing; Basis.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 11. Briefs and Oral Arguments

§ 2625.1. Briefs.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2625.2. Oral Argument.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 12. Submission of Proceeding

§ 2626.1. Submission of Proceeding.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 13. Petitions for Reconsideration

§ 2627.1. Filing.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2627.2. Contents.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

[The next page is 715.]

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2627.3. Response.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 14. Intervention

§ 2628.1. Intervention of Right.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2628.2. Common Legal Representative.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2628.3. Procedure.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 15. Intervenor's Fees and Expenses

§ 2629.1. Purpose.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.2. Definitions.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.3. Requirements for Awards.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.4. Request for Finding of Eligibility; Time; Contents.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.5. Response.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.6. Motion to Change Time Periods.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.7. Ruling.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.8. Request for Award.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.9. Amended Request for Award.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.10. Decision Awarding Compensation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 and with an editorial correction granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Editorial correction of HISTORY 7. and text (Register 91, No. 17).
10. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.11. Computation of Compensation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2629.12. Time for Payment; Allowance of Award.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 16. Sample Forms

§ 2630.1. Forms.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.08, Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.2. Petition for Hearing.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register

91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Editorial correction of form (Register 91, No. 17).

10. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.3. Answer.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Editorial correction of form (Register 91, No. 17).

10. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.4. Motion to Conduct Prehearing Conference.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.5. Motion to Dismiss.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).

7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.

8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.

9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.6. Petition to Intervene.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.

2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.

3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.

5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.7. Request for Finding of Eligibility to Seek Compensation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 and with an editorial correction granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Editorial correction of form (Register 91, No. 17).
10. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.8. Request for Award of Compensation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.9. Verification (for Corporation).

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.10. Verification Where Applicant Is Absent from County of Attorney's Office.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register

90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.

4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90,No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.11. Verification (for Individuals or Partnerships).

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

§ 2630.12. Certificate of Service by Mail.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.05(c), and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, May 4, 1989, Supreme Court No. S007838, pp. 24–25, 89 Daily Journal DAR 5837.

HISTORY

1. New section filed 5–30–89 as an emergency; operative 5–30–89 (Register 89, No. 24). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–27–89.
2. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–27–89 as an emergency; operative 9–27–89 (Register 89, No. 40). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–25–90.
3. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 1–23–90; operative 1–25–90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–25–90.
4. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 5–24–90; operative 5–25–90 (Register 90, No. 27). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 9–24–90.
5. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 9–24–90; operative 9–24–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 1–22–91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 9–24–90 order submitted to OAL 10–12–90 and disapproved by OAL 11–13–90 (Register 90, No. 47).
7. Request to readopt section on an emergency basis pursuant to Government Code section 11346.1 granted and filed 11–13–90; operative 11–13–90 (Register 90, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–13–91 or emergency language will be repealed by operation of law on the following day.
8. Request to readopt section on an emergency basis pursuant to Government Code section 22346.1 granted and filed 3–13–91; operative 3–13–91 (Register 91, No. 17). A Certificate of Compliance must be transmitted to OAL by 7–11–91 or emergency language will be repealed by operation of law on the following day.
9. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 39).

Article 17. Intervenor Compensation in Departmental Proceedings

§ 2631.1. Purpose.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. Repealer and new section filed 11–14–91 as an emergency; operative 11–15–91 (Register 92, No. 7). A Certificate of Compliance must be transmitted to OAL 3–16–92 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3–13–92 as an emergency; operative 3–13–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–13–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 3–13–92 order transmitted to OAL 7–9–92; disapproved by OAL and order of repeal as to 3–13–92 order filed on 8–20–92 (Register 92, No. 34).
4. New section filed 8–20–92 as an emergency; operative 8–20–92 (Register 92, No. 34). A Certificate of Compliance must be filed with OAL 12–18–92 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 8–20–92 order transmitted to OAL 2–1–93; disapproved by OAL and order of repeal as to 8–20–92 order filed on 2–1–93 (Register 93, No. 6).

§ 2631.2. Definitions.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. Repealer and new section filed 11–14–91 as an emergency; operative 11–15–91 (Register 92, No. 7). A Certificate of Compliance must be transmitted to OAL 3–16–92 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3–13–92 as an emergency; operative 3–13–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 7–13–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 3–13–92 order transmitted to OAL 7–9–92; disapproved by OAL and order of repeal as to 3–13–92 order filed on 8–20–92 (Register 92, No. 34).
4. New section filed 8–20–92 as an emergency; operative 8–20–92 (Register 92, No. 34). A Certificate of Compliance must be filed with OAL 12–18–92 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 8–20–92 order transmitted to OAL 2–1–93; disapproved by OAL and order of repeal as to 8–20–92 order filed on 2–1–93 (Register 93, No. 6).

§ 2631.3. Request for Eligibility.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 7–18–91 as an emergency; operative 7–18–91 (Register 91, No. 46). A Certificate of Compliance must be transmitted to OAL by 11–15–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer and new section filed 11–14–91 as an emergency; operative 11–15–91 (Register 92, No. 7). A Certificate of Compliance must be transmitted to OAL 3–16–92 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–13–92 as an emergency; operative 3–13–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 7–13–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–13–92 order transmitted to OAL 7–9–92; disapproved by OAL and order of repeal as to 3–13–92 order filed on 8–20–92 (Register 92, No. 34).
5. New section filed 8–20–92 as an emergency; operative 8–20–92 (Register 92, No. 34). A Certificate of Compliance must be filed with OAL 12–18–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–20–92 order transmitted to OAL 2–1–93; disapproved by OAL and order of repeal as to 8–20–92 order filed on 2–1–93 (Register 93, No. 6).

§ 2631.4. Finding of Eligibility.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 7–18–91 as an emergency; operative 7–18–91 (Register 91, No. 46). A Certificate of Compliance must be transmitted to OAL by 11–15–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer and new section filed 11–14–91 as an emergency; operative 11–15–91 (Register 92, No. 7). A Certificate of Compliance must be transmitted to OAL 3–16–92 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–13–92 as an emergency; operative 3–13–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 7–13–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–13–92 order transmitted to OAL 7–9–92; disapproved by OAL and order of repeal as to 3–13–92 order filed on 8–20–92 (Register 92, No. 34).
5. New section filed 8–20–92 as an emergency; operative 8–20–92 (Register 92, No. 34). A Certificate of Compliance must be filed with OAL 12–18–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–20–92 order transmitted to OAL 2–1–93; disapproved by OAL and order of repeal as to 8–20–92 order filed on 2–1–93 (Register 93, No. 6).

§ 2631.5. Request for Compensation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 7–18–91 as an emergency; operative 7–18–91 (Register 91, No. 46). A Certificate of Compliance must be transmitted to OAL by 11–15–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer and new section filed 11–14–91 as an emergency; operative 11–15–91 (Register 92, No. 7). A Certificate of Compliance must be transmitted to OAL 3–16–92 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–13–92 as an emergency; operative 3–13–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 7–13–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–13–92 order transmitted to OAL 7–9–92; disapproved by OAL and order of repeal as to 3–13–92 order filed on 8–20–92 (Register 92, No. 34).
5. New section filed 8–20–92 as an emergency; operative 8–20–92 (Register 92, No. 34). A Certificate of Compliance must be filed with OAL 12–18–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–20–92 order transmitted to OAL 2–1–93; disapproved by OAL and order of repeal as to 8–20–92 order filed on 2–1–93 (Register 93, No. 6).

§ 2631.6. Order for Compensation.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Section 1861.10(b), Insurance Code; and *CalFarm, et al.* v. *Deukmejian, et al.*, 48 Cal.3d 805 (1989).

HISTORY

1. New section filed 7–18–91 as an emergency; operative 7–18–91 (Register 91, No. 46). A Certificate of Compliance must be transmitted to OAL by 11–15–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer and new section filed 11–14–91 as an emergency; operative 11–15–91 (Register 92, No. 7). A Certificate of Compliance must be transmitted to OAL 3–16–92 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 3–13–92 as an emergency; operative 3–13–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 7–13–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–13–92 order transmitted to OAL 7–9–92; disapproved by OAL and order of repeal as to 3–13–92 order filed on 8–20–92 (Register 92, No. 34).
5. New section filed 8–20–92 as an emergency; operative 8–20–92 (Register 92, No. 34). A Certificate of Compliance must be filed with OAL 12–18–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–20–92 order transmitted to OAL 2–1–93; disapproved by OAL and order of repeal as to 8–20–92 order filed on 2–1–93 (Register 93, No. 6).

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Subchapter 4.7. Private Passenger Automobile Rating Factors

Article 1. Scope

§ 2632.1. Scope.

This subchapter sets forth the criteria to be used for setting rates and premiums for private passenger automobile insurance as defined in California Insurance Code Section 660; said criteria do not apply to private passenger automobiles insured pursuant to commercial policies. This subchapter also sets forth criteria pertaining to good driver discounts, the availability of good driver discount policies from insurers, and the determination of chargeable principally at-fault accidents.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian*, 48 Cal.3d 805 (1989). Reference: Sections 1861.02(a) and (b), 1861.025 and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3-17-94 order including repealer and new article 1 and section transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

Article 2. Definitions

§ 2632.2. Rating Factors.

(a) The term "rating factor" is defined as any factor, including discounts, used by an insurer which establishes or affects the rates, premiums, or charges assessed for a policy of automobile insurance.

(b) Notwithstanding subsection (a), the following matters are not rating factors and nothing in this section shall prevent or limit an insurer from considering such matters, with the prior approval of the Commissioner, in the development of rates and premiums:

(1) type or limits of coverage or deductibles;

(2) for automobile collision coverage, as described in California Insurance Code Section 660, the value, the cost of repair, or the auto symbol of the insured vehicles. The term "auto symbol" as used in these regulations means any symbol based on vehicle price, repair cost, or damageability which is used to calculate any rate or premium for private passenger automobile insurance;

(3) for automobile physical damage coverage, as described in California Insurance Code Section 660, or comprehensive coverage, as described in California Insurance Code Section 11580.07, the make, model, value, cost of repair, or the auto symbol of the insured vehicles.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code. Reference: Section 1861.02(a), Insurance Code.

HISTORY

1. Certificate of Compliance as to 3-17-94 order including repealer and new article 2 and section transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

§ 2632.3. Class Plan.

The term "class plan" means the following:

(a) the schedule of rating factors and discounts, and their order and manner of analysis as required by Section 2632.7, in the development of rates and premiums charged for a policy of automobile insurance.

(b) in accordance with Section 2632.2, the analysis or consideration of types or limits of coverage or deductibles, make, model, value, cost of repair, and auto symbols of the insured vehicles.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code. Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3-17-94 order including repealer and new section transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

Article 3. Rating Factors

§ 2632.4. Use of Rating Factors.

(a) No insurer shall use a rating factor which is not set forth in these regulations and no insurer shall adopt any rating factor based in whole or in part upon the race, language, color, religion, national origin, ancestry, age, political affiliation, or sexual orientation of any person.

(b) No insurer shall use a rating factor, discount, types of limits of coverages or deductibles, make, model, value, cost of repair, or auto symbol of the insured vehicle in the development of rates in a manner that does not bear a substantial relationship to loss.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code. Reference: Sections 1861.02(a) and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3-17-94 order including repealer and new article 3 and section transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34). For prior history, see Register 94, No. 11.
2. Amendment of subsection (a) filed 7-5-96; operative 8-4-96 (Register 96, No. 27).

§ 2632.5. Rating Factors.

(a) Every insurer offering or issuing a policy of automobile insurance shall establish a class plan for the calculation of rates that specifies rating factors in accordance with this section and which complies with the good driver discount requirements of California Insurance Code Section 1861.02 and all other statutes providing discounts in automobile insurance rates and premiums.

(b) Each insurer may only use the characteristics of one driver to rate each vehicle except for as provided in section 2632.5(d)(13) and section 2632.5(c)(2). If there are more vehicles on a policy than drivers, the insurer shall assign either a rate for an undesignated driver or the lowest rate for all driver related factors to the excess vehicles.

(c) An insurer's class plan, and all rates and premiums determined in accordance therewith, shall utilize the following rating factors (the "Mandatory Factors") for bodily injury liability, property damage liability, medical payments, uninsured motorist, collision, and comprehensive coverages:

(1) "First Mandatory Factor," as used in subchapter 4.7, is the insured's driving safety record per California Insurance Code Section 1861.02(a)(1). This factor means the following for the driver rated on the insured vehicle:

(A) the public record of traffic violation convictions available from the California Department of Motor Vehicles, together with similar public records of traffic violation convictions that are available from other jurisdictions (hereinafter sometimes referred to as the "Motor Vehicle Report" or "MVR"). To determine a driver's safety record for purposes of California Insurance Code Sections 1861.02(a)(1) and 1861.025, each insurer shall verify a driver's current driving safety record as contained in the MVR for every driver listed on the policy at the time of policy application, and for each new driver added to the policy at the time the driver is added, and no less frequently than every 36 months thereafter, if the policy remains in effect. No insurer shall rate or underwrite a renewal policy based upon an MVR older than 36 months at the time the policy is renewed. However, nothing in this section shall be construed to preclude an insurer from obtaining, for the time periods set forth in this regulation, a report from an insurance-support organization or other third party which establishes that a new MVR would contain only the information already found on the MVR the insurer most recently obtained. When an insurer has such a report for a particular driver, the insurer is not required to obtain a new MVR for that driver. Additionally, nothing in this section shall be construed to preclude an insurer from granting a discount based on a driving record longer than 36 months as long as the insurer verifies a driver's record as set forth in this section;

(B) the principally at-fault accidents, as determined pursuant to section 2632.13;

(C) all convictions for violations of Vehicle Code Sections 23140, 23152, or 23153 must be treated as the highest surchargeable violation; however, other Vehicle Code convictions may receive equal treatment.

(2) "Second Mandatory Factor" as used in Subchapter 4.7, is the number of miles he or she drives annually, per California Insurance Code Section 1861.02(a)(2). This factor means the estimated annual mileage for the insured vehicle during the 12 month period following the inception of the policy. Insurers may not retroactively adjust premiums based on actual miles driven unless notice is provided to the policy holder prior to the effective date of the policy. Estimated annual mileage shall be determined only as follows and except as otherwise set forth in this section, an insurer shall use the applicant's estimated annual mileage:

(A) For new business or vehicles added during the term of the policy:

(i) During the application process, or when a vehicle is being added or replaced during the term of the policy, the applicant shall provide the miles he or she expects each vehicle to be insured will be driven during the 12 month period following policy inception. The insurer may also require or request, as set forth in sections (C) and (D) below, information from the applicant during this process necessary to support the estimate.

(ii) If an applicant does not provide the estimated annual miles he or she expects to drive or the information required pursuant to (C) below or if the information provided does not support the applicant's estimated annual miles, an insurer may issue a policy using a reasonable objective mileage estimate based upon the information provided pursuant to sections (C), (D) and (E) below or, if a reasonable estimate cannot be determined, using a default annual mileage figure which has been filed with and approved by the Commissioner pursuant to California Insurance Code Section 1861.02. Before doing so, the insurer shall inform the applicant of the mileage figure which it will use to rate the policy.

(iii) For the purposes of this section, when one or more vehicles are added during the term of the policy, "applicant" shall be construed to mean "policyholder" when the context so requires.

(B) For renewal business:

(i) During the renewal process, an insurer shall, at least every three years, request a policyholder to provide the estimated annual miles he or she expects each vehicle to be insured will be driven during the 12 month period following policy renewal. The insurer may also require or request, as set forth in sections (C) and (D) below, information from the policyholder necessary to support the estimate. The request may be made with the renewal notice. An insurer may, if not requesting updated information, use the mileage figure from the expiring policy or use a reasonable objective mileage estimate solely based upon the information set forth in (C), (D) and (E) below.

(ii) If, during the renewal process the insurer receives none or only some of the information requested in (i) above:

1. The insurer may renew the policy using either the mileage figure from the expiring policy or using a reasonable objective mileage estimate based upon the information set forth in (C), (D) and (E) below, whichever it determines is the most reasonable.

2. The insurer may, if it lacks sufficient information to determine a reasonable estimate, renew the policy using a default annual mileage figure which has been filed with and approved by the Commissioner pursuant to California Insurance Code Section 1861.02.

(iii) Before renewing a policy, the insurer shall provide the applicant written notice that highlights the mileage figure for the expiring policy and the mileage figure for the renewal policy.

(C) An insurer may require an applicant or policyholder to provide the following information:

1. If the vehicle is used for commute purposes, the location of the workplace, school, or other destination where the vehicle will be driven and, if applicable, an estimate of the number of miles the vehicle will be driven in the course of employment;

2. The number of days per week the vehicle will be used for commuting;

3. An estimate of the number of miles to be driven for pleasure or other purposes;

4. The approximate total number of miles driven for any time period within, but not to exceed, the previous 24 months;

5. The reason for any differences between the estimate for the upcoming 12 months and the miles driven the previous 12 months; and

6. The current odometer reading of the vehicle to be insured.

(D) An insurer may request but shall not require an applicant or policyholder to provide the following information:

1. Service records which document the odometer reading of the vehicle to be insured.

2. The use of technological devices provided by the insurer or otherwise made available to the insured that accurately collect vehicle mileage information.

(E) An insurer may obtain and use smog check odometer readings from the California Bureau of Automotive Repair to estimate annual miles driven.

(F) All mileage rating rules that direct the selection of a mileage rating relativity shall be filed with and approved by the Commissioner in a class plan filing. This includes use of multiple mileage rating bands and use of default and/or average mileage rating relativities.

(G) In no event shall an insurer require a policyholder to provide information from a prior insurer to confirm mileage estimated or driven.

(H) Nothing in this section shall be construed to affect the ability of an insurer to decline to issue, cancel, or nonrenew a policy in accordance with any other applicable provision of California law.

(3) "Third Mandatory Factor" as used in Subchapter 4.7, is the number of years of driving experience the insured has, per California Insurance Code Section 1861.02(a)(3). This factor means number of years of experience that the driver rated on the insured vehicle has been licensed to drive in any jurisdiction. To the extent that a policy provides coverage for motorcycles or motor–driven cycles, as defined in California Vehicle Code Sections 400 and 405, this factor shall refer to the number of years that the driver rated on the insured vehicle has been licensed to drive such vehicles in any jurisdiction.

(d) In addition to the rating factors set forth in subdivision (c), an insurer's class plan, and all rates and premiums determined in accordance therewith, may utilize the following optional rating factors (the "Optional Factors"):

(1) Type of vehicle;

(2) Vehicle performance capabilities, including alterations made subsequent to original manufacture;

(3) Type of use of vehicle (pleasure only, commute, business, farm, commute mileage, etc.);

(4) Percentage use of the vehicle by the rated driver;

(5) Multi–vehicle households;

(6) Academic standing of the rated driver;

(7) Completion of driver training or defensive driving courses by the rated driver;

(8) Vehicle characteristics, including engine size, safety and protective devices, damageability, repairability, and theft deterrent devices;

(9) Gender of the rated driver;

(10) Marital status of the rated driver;

(11) Persistency:

(A) At policy renewal, persistency credit may be applied by an insurer or affiliate for the current named insured. Persistency credit may also be applied when issuing a separate new automobile policy for a person who is not the named insured on a policy, but is otherwise currently insured.

(B) An insurer shall not apply a persistency credit for a new policy issued to an individual, unless that individual is currently insured. Nor shall any insurer apply persistency, at any time, when based in whole or in part upon automobile insurance coverage provided by a non–affiliated insurer.

(C) This subsection shall not be construed to expand or restrict an insurer's ability to obtain evidence of a person's driving safety record. However, when such evidence concerns proof of prior insurance, this subsection shall apply.

(D) For purposes of this subsection, "currently insured" means a person who is presently covered for automobile insurance by the insurer or

affiliate, other than as an unnamed person who is covered under a permissive user or similar provision.

(E) As used in this subsection, "affiliate" has the same meaning as defined in California Insurance Code section 1215.

(12) Non-smoker;

(13) Secondary Driver Characteristics. For drivers not assigned as a primary or secondary driver to another vehicle, this factor may be composed of a combination of the following factors: Safety Record, Years Licensed, Gender, Martial Status, Driver Training, and Academic Status;

(14) Multi-policies with the same, or an affiliated, company;

(15) Relative claims frequency. This factor shall contain a maximum of twenty categories and shall reflect where the insured vehicle is garaged. These categories shall be based on grouping the zip codes in the state into bands. Alternately, the bands could be based on grouping the census tracts in the state. Each band shall contain areas with a similar average claims frequency. In the event that the data for a zip code or census tract is not fully credible, the adjustment process described in Section 2632.9(d) shall be followed;

(16) Relative claims severity. This factor shall contain a maximum of twenty categories and shall reflect where the insured vehicle is garaged. These categories shall be based on grouping the zip codes in the state into bands. Alternately, the bands could be based on grouping the census tracts in the state. Each band shall contain areas with a similar average claims severity. In the event that the data for a zip code or census tract is not fully credible, the adjustment process described in Section 2632.9(d) shall be followed.

(e) The three mandatory factors may not be combined with any other factor, except Percent Use, Academic Standing, Gender, Marital Status, and Driver Training may be combined with number of years of driving experience. If an insurer elects to combine number of years of driving experience with any other optional factor as provided in this Section, the insurer shall demonstrate in its class plan that the rating factors used in combination, when considered individually, comply with the weight ordering requirements of Section 2632.8.

NOTE: Authority cited: Section 1861.02, Insurance Code; and *CalFarm Insurance Company v. Deukmejian* (1989) 48 Cal. 3d 805. Reference: Sections 1861.02, 1861.025, 1861.05, 11628 and 11628.3, Insurance Code.

HISTORY

1. New section filed 12-15-89 as an emergency; operative 12-15-89 (Register 90, No. 3). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4-14-90.
2. New section filed 4-13-90 as an emergency; operative 4-15-90 (Register 90, No. 17). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 8-13-90.
3. New section filed 8-6-90 as an emergency; operative 8-6-90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12-4-90 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 8-13-90 as an emergency; operative 8-13-90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12-12-90 or emergency language will be repealed by operation of law on the following day.
5. Readoption of 8-6-90 emergency order filed 11-30-90 as an emergency; operative 11-30-90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4-1-91 or emergency language will be repealed by operation of law on the following day.
6. Readoption of 8-13-90 emergency order filed 12-12-90 as an emergency; operative 12-12-90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4-11-91 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of HISTORY 6 correcting operative date (Register 91, No. 21).
8. Readoption of 11-30-90 emergency order filed 3-29-91 as an emergency; operative 3-29-91 (Register 91, No. 21). A Certificate of Compliance must be transmitted to OAL by 7-29-91 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order filed 7-26-91 as an emergency; operative 7-26-91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11-25-91 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order filed 11-27-91 as an emergency; operative 11-27-91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3-26-92 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order, including repealer of italicized text, filed 3-25-92; operative 3-25-92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7-23-92 or emergency language will be repealed by operation of law on the following day.
12. Editorial correction restoring article 3 heading (Register 92, No. 20).
13. Readoption of emergency order filed 7-22-92 as an emergency; operative 7-22-92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11-19-92 or emergency language will be repealed by operation of law on the following day.
14. Readoption of emergency order filed 11-19-92 as an emergency; operative 11-19-92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3-19-92 or emergency language will be repealed by operation of law on the following day.
15. Readoption of emergency order filed 3-26-93 as an emergency; operative 3-26-93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7-26-93 or emergency language will be repealed by operation of law on the following day.
16. Readoption of emergency order filed 7-22-93 as an emergency; operative 7-22-93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11-19-93 or emergency language will be repealed by operation of law on the following day.
17. Readoption of emergency order filed 11-18-93 as an emergency; operative 11-18-93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3-18-94 or emergency language will be repealed by operation of law on the following day.
18. Readoption of emergency order filed 3-17-94 as an emergency; operative 3-17-94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7-14-94 or emergency language will be repealed by operation of law on the following day.
19. Certificate of Compliance as to 3-17-94 order including repealer and new section transmitted to OAL 7-12-94; disapproved by OAL 8-23-94 (Register 94, No. 34).
20. New section filed 2-23-95 as an emergency; operative 2-23-95 (Register 95, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-23-95 or emergency language will be repealed by operation of law on the following day.
21. New section including amendment of subsection (c)(22) refiled 7-5-95 as an emergency; operative 7-5-95 (Register 95, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-2-95 or emergency language will be repealed by operation of law on the following day.
22. Repealed by operation of Government Code section 11346.1(g) 11-3-95 (Register 96, No. 37).
23. Editorial correction of subsection (c)(22) and HISTORY 21 (Register 95, No. 49).
24. New section refiled 12-5-95 as an emergency; operative 12-5-95 (Register 95, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-3-96 or emergency language will be repealed by operation of law on the following day.
25. Repealed by operation of Government Code section 11346.1(g) (Register 96, No. 27).
26. New section filed 7-5-96; operative 8-4-96 (Register 96, No. 27).
27. Editorial correction of subsection (d)(10) and adding new HISTORY 22 and HISTORY renumbering (Register 96, No. 37).
28. Repealer of subsection (d)(14) and new subsection (d)(14) filed 5-5-97 as an emergency; operative 5-5-97 (Register 97, No. 19). A Certificate of Compliance must be transmitted to OAL by 9-2-97 or emergency language will be repealed by operation of law on the following day.
29. Reinstatement of subsection (d)(14) as it existed prior to 5-5-97 emergency amendment by operation of Government Code section 11346.1(f) (Register 97, No. 38).
30. Repealer of subsection (d)(14) and new subsection (d)(14) filed 9-15-97; operative 9-15-97 (Register 97, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-13-98 or emergency language will be repealed by operation of law on the following day.
31. Reinstatement of subsection (d)(14) as it existed prior to 9-15-97 emergency amendment by operation of Government Code section 11346.1(f) (Register 98, No. 10).
32. Repealer and new subsection (d)(14) filed 3-5-98; operative 3-5-98 pursuant to Government Code section 11343.4(d) (Register 98, No. 10).
33. Editorial correction inserting word inadvertently omitted from subsection (b) (Register 99, No. 41).
34. Editorial correction of subsection (b) (Register 2002, No. 17).
35. Amendment of subsection (d)(11) and new subsections (d)(11)(A)-(E) filed 8-27-2002; operative 9-26-2002 (Register 2002, No. 35).
36. Amendment of subsection (c)(1)(A) and NOTE filed 2-27-2006; operative 4-28-2006 (Register 2006, No. 9).
37. Amendment of subsections (d)(15)-(e) filed 7-14-2006; operative 8-13-2006 (Register 2006, No. 28).
38. Amendment of subsection (c)(2) and new subsections (c)(2)(A)-(H) filed 12-29-2006; operative 2-27-2007 (Register 2006, No. 52).

§ 2632.6. Discounts.

(a) Insurers may offer discounts to premiums for any of the following:

(1) completion of driver training or defensive driving courses;

(2) any other discount provided by law.

(b) Notwithstanding subsection (a), no discount shall be offered or used by any insurer that is not uniformly promoted and offered to the public.

(c) The insurer's class plan shall specify the nature of the discounts and the manner in which they will be promoted and offered to the public.

NOTE: Authority cited: Sections 1861.02, 11628, 12921 and 12926, Insurance Code. Reference: Sections 1861.02, 1861.05 and 11628, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer and new section transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

§ 2632.7. Analysis of Rating Factors.

(a) The determination of the initial relativities to associate with a rating factor shall be established by performing a sequential analysis. The sequential analysis shall remove the variation in loss costs already explained by prior factors.

(b) The sequential analysis shall analyze the rating factors one at a time, in the following order:

1. The first mandatory factor;
2. The second mandatory factor;
3. The third mandatory factor;
4. Any and all optional factors used by the insurer in accordance with subsection 2632.5(d). The order of analysis of the optional factors shall be determined by the insurer, with the exception that frequency band and severity band shall be analyzed last.

(c) The initial relativities, as developed, shall be balanced to a weighted average of 1.0 for multiplicative factors or balanced to a weighted average of 0.0 for additive factors. The weighting factor for the weighted average shall be the number of exposures from the data chosen for use in section 2632.8(b).

(d) The results of the sequential analysis shall be submitted to the Department in a computer file in a format specified by the Commissioner. Individual policy holder's name and street address need not be submitted provided the insurer includes a unique identifying number which permits tracking of the information should questions concerning data quality arise.

NOTE: Authority cited: Section 1861.02, Insurance Code; and *CalFarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805. Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. New section heading and text filed 9–26–94 as an emergency; operative 9–26–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–24–95 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 94, No. 34.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 5).
3. New section filed 2–2–95 as an emergency; operative 2–2–95 (Register 95, No. 5). A Certificate of Compliance must be transmitted to OAL by 6–2–95 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 6–2–95 as an emergency; operative 6–2–95 (Register 95, No. 22). A Certificate of Compliance must be transmitted to OAL by 10–2–95 or emergency language will be repealed by operation of law on the following day.
5. New section refiled 10–12–95 as an emergency; operative 10–12–95 (Register 95, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–9–96 or emergency language will be repealed by operation of law on the following day.
6. Repealed by operation of Government Code section 11346.1(g) (Register 96, No. 27).
7. New section filed 7–5–96; operative 8–4–96 (Register 96, No. 27).
8. New subsection (b) filed 9–11–96; operative 9–11–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 37).

§ 2632.8. Factor Weights.

(a) For each type of coverage, factor weights shall be calculated for each of the three mandatory factors listed in Section 2632.5(c)(1) through (3) and for each of the optional factors the insurer elects to utilize in its class plan from Section 2632.5(d). Solely for the purpose of calculating factor weights, bodily injury coverage may be combined with property damage coverage and comprehensive coverage may be combined with collision coverage.

(b) The data used to compute the weight shall be based on one of the following:

(1) all of the subject company's currently insured vehicles;

(2) the same data set used to perform the sequential analysis in Section 2632.7; or

(3) the set of insured vehicles that may be published by the Department of Insurance.

(c) The weight of a rating factor is defined as follows:

For additive and multiplicative factors, the weight of Rating Factor j $= \sum | (R_i - R) | * E_i * B$. For additive and multiplicative factors, compute, $| (R_i - R) | * E_i * B$ for each category of rating factor j. The weight for rating factor j is then the sum of all these numbers (as i runs across all categories of rating factor j).

Where R_i — Balanced relativity of the i^{th} category of rating factor j (the superscript j is omitted, the same below)

R — Weighted average relativity (the balanced relativities are weighted by the percent of exposure so that R should be equal to 0 for additive factors and 1 for multiplicative factors)

E_i — Percent of exposure in the i^{th} category of rating factor j

B —Base rate

(d) The weights of the factors, as calculated in subdivision (c), must align in decreasing order of importance as follows: driving safety record must have the most weight followed by annual miles driven followed by years of driving experience followed by each individual weight of each optional factor. If the weights are not in the order as specified herein then the insurer must correct the relativities of the rating factors as follows:

(1) Select the rating factors to be modified.

(A) Compute the weighted average of the initial relativities for the factor over the data set selected in subdivision (b) herein;

(B) Subtract the weighted average from each initial relativity;

(C) Multiply the result of step (B) by a correction factor;

(D) Add the result of step (C) to the weighted average.

The formula for this correction is:

NR = (IR – WA) * CF) + WA

Where: NR = New Relativity
IR = Initial Relativity
CF = Correction Factor
WA = Weighted Average

(2) Repeat process of subdivision (d)(1)(A) through (D) if it is necessary to correct the weight of any of the rating factors.

(3) The weight of a corrected rating factor may not exceed the corrected weight of the succeeding rating factor, in decreasing order of importance, by more than 0.25.

(4) If two rating factor weights are not in the order specified in this Section, the subject company shall have the right to increase or decrease the weight of either factor to achieve compliance. This right shall apply to both the optional rating factors and the mandatory rating factors.

NOTE: Authority cited: Section 1861.02, Insurance Code; and *CalFarm Insurance Company* v. *Deukmejian*, (1989) 48 Cal.3d 805. Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer and new section heading transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.
2. New section filed 7–5–96; operative 8–4–96 (Register 96, No. 27).
3. Amendment filed 12–12–2002; operative 1–11–2003 (Register 2002, No. 50).
4. Amendment of subsections (a), (c) and (d) and new subsection (d)(4) filed 7–14–2006; operative 8–13–2006 (Register 2006, No. 28).

§ 2632.9. Use of Data.

(a) An insurer that does not currently have credible data to support any of the categories for any of the rating factors listed in section 2632.5(c) and (d) may use the following for each such factor in their class plans filed within three years of the effective date of these regulations. An insurer may elect to use more than one of the listed data sources, provided each data source is identified as being primary, secondary, or third etc. The primary data source must be used for all rating factors included in that data source. The secondary data source can be used only if the primary data source does not have information on a specific rating factor or as needed to supplement credibility. The secondary data source must be used for all rating factors included in that data source before using a third

data source. Similarly, the third data source can only be used if the secondary data source does not have information on a specific rating factor or as needed to supplement credibility, etc.:

(1) their own data, interpolating or otherwise actuarially adjusting the data to fit the categories; or

(2) data from another company; or

(3) data from an advisory organization; or

(4) the indicated relativity from another insurer with a similar book of business; or

(5) data that may be published by the Department; or

(6) approved relativities from another insurer's approved class plan.

(b) For class plans filed more than three years after the effective date of this regulation, an insurer may use only one of the following for every rating factor:

(1) the insurer's own data; or

(2) the insurer's own data and the data from a single alternative source of primary data; or,

(3) data from a single alternative source of primary data, such as an advisory organization; or,

(4) the indicated relativity from the approved plan of another insurer with a similar book of business; or

(5) data that may be published by the Department; or,

(6) data that may be published by the Department and the insurer's own data.

(c) When an insurer uses data from another source (as allowed in 2632.9(a) & (b)) they may use only the raw data before any adjustment factors have been applied (e.g., loss adjustment expenses, trending, loss development, etc.).

(d) If an insurer elects to use the optional factors average relative frequency band and severity band as listed in Section 2632.5(d)(15) and (16), the bands described in Section 2632.9(e) may be used. Use of the data described in section 2632.9(e) shall not be considered a data source for the purposes of section 2632.9(b) and restrict an insurer from selecting one of the options listed there. An insurer may also elect to use their own data for developing the frequency and severity bands. In the event that an insurer lacks credible data at the census tract level, they shall use zip code data. If the insurer's own zip code data is not fully credible, it shall use the claims frequency and severity for the zip code that is published in the manual described in Section 2632.9(e) either:

(1) directly as it is published, or

(2) to credibility adjust their own data. In the case where the manual indicates that the rate published in the manual has been credibility adjusted, an insurer may:

(A) use the credibility adjusted rate in the manual as the complement of credibility, or

(B) combine the unadjusted data published in the manual with its own unadjusted data. If this combined data is still not credible, then an insurer may elect to use as the compliment of credibility either:

1. the rate published in the manual for the CAARP territory that the zip code is a member of, or

2. the rate based on their own data or data from the manual from another grouping of contiguous whole zip codes, selected by the insurer, that is fully credible and contains said zip code.

(e) The frequency and severity rates and possible band assignments for each zip code in California are shown in the manual entitled California Private Passenger Auto Frequency and Severity Bands. Pursuant to the provision of Section 11344, Government Code, this regulation is not printed in full herein. The Insurance Commissioner has approved the separate manual designated in this Section. This manual was filed with the Secretary of State of the State of California on July 5, 1996, but for the present is separately published, not as part of the California Administrative Code. The manual referenced in this section may be examined at the office of the Insurance Commissioner in San Francisco, Los Angeles, and Sacramento.

(f) Zip codes not included in the manual described under (e) shall be assigned to bands as follows:

(1) new zip codes that were split off from an old zip code, shall use the band of the former zip code for that area;

(2) new zip codes that combined all or parts of other zip codes shall be assigned to one of the old zip codes that was used to make the new zip code;

(3) all other zip codes not in (e) shall be assigned by the insurer based on the band of any zip code that borders it.

(4) for assignments made under (2) or (3), insurers must choose the same zip code to be used for all band assignments.

NOTE: Authority cited: Section 1861.02, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805. Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer and new section heading transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

[The next page is 728.15.]

2. New section filed 7–5–96; operative 8–4–96 (Register 96, No. 27).

§ 2632.10. Approval of Class Plan.

(a) Except as provided in subpart (b) of this section, no insurer may hereafter use a class plan, or charge or collect a premium which does not comply with the provisions of this subchapter or with the provisions of the California Insurance Code. No insurer may offer, sell or renew a policy of automobile insurance, or collect a premium for a policy of automobile insurance which is not calculated in accordance with a class plan that complies with this subchapter.

(b) Prior to the approval of a class plan which has been submitted to the Commissioner in good faith and which complies with the provisions of this chapter and the Insurance Code, an insurer may continue to use rates and premiums that are calculated pursuant to a class plan that has been approved by the Commissioner.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code. Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer and new section transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

§ 2632.11. Submission of Class Plans, Symbols, and Implementation Data.

(a) Every insurer offering or selling a policy of private passenger automobile insurance shall submit a class plan which complies with this subchapter to the Commissioner for review. The following shall apply to all class plans submitted in accordance with this subchapter:

(1) A class plan shall be considered to have been received by the Commissioner on the date that it is received by the Department's Rate Filing Bureau in San Francisco.

(2) Within 15 working days of receipt, the Commissioner shall review filings submitted pursuant to this subchapter for completeness. If the Commissioner determines that the class plan is not complete, notice stating the grounds for incompleteness will be given to the insurer within the 15 working day period and the filing of the class plan will be rejected.

(3) Rejection of the filing of a class plan for incompleteness shall not relieve any insurer of the duty to file a complete class plan.

(b) Class plans submitted for review shall contain a completed class plan application, in a form prescribed by the Commissioner, and underwriting guidelines.

(c) For class plan changes submitted in accordance with the 2006 amendments to Section 2632.8, every class plan shall be submitted in conjunction with an accompanying rate filing and shall be subject to the following conditions:

(1) Class plan applications submitted in accordance with subdivision (c) shall include a transition plan. The transition plan shall consist of at least two annual class plan filings. The first of the two annual class plan filings shall be submitted within 30 days of the date the 2006 amendments to Section 2632.8 are filed with the Secretary of State. Insurers must fully comply with Section 2632.8 within two years of the date the 2006 amendments to Section 2632.8 are filed with the Secretary of State.

(2) An insurer shall revise factor weights in each of the annual class plan filings to correct non–compliance with Section 2632.8.

(3) The amount of non–compliance shall be based upon the insurer's class plan in effect on December 31, 2005.

(A) The amount of non–compliance shall be established by comparing the factor weight for each optional rating factor to the factor weight for the third mandatory factor, years driving experience.

(B) The formula for establishing the amount of non–compliance shall be: (weight of optional factor divided by weight of years driving experience) minus 1.00.

(C) If the resulting calculation is greater than or equal to zero, the optional factor does not comply and must be corrected. If the calculation is less than zero, the factor is in compliance.

(4) The first annual filing must correct at least 15% of the current amount of non–compliance for every rating factor that is not in compliance. The transition plan shall be demonstrated in each filing as follows:

(A) The insurer must demonstrate that it has achieved the required amount of correction in each filing. This shall be done by calculating the formula in subdivision (c)(3)(B) of this Section for the current class plan and newly–submitted class plan for each optional rating factor to show that the required amount of correction has been made. The required amount of correction to be demonstrated in the newly–submitted class plan can be achieved by tempering the optional rating factor or pumping years driving experience and the mandatory factors as necessary, relative to the rating factor weights used in the formula specified in subdivision (c)(3)(B) of this Section. Alternatively, the required amount of correction can be achieved by simultaneously tempering the optional rating factor and pumping years driving experience and other mandatory factors as necessary, relative to the rating factor weights used in the formula specified in subdivision (c)(3)(B) of this Section.

(B) For each filing submitted on an annual or more frequent basis to comply with subdivision (c) of this Section, the insurer must perform the weight test and correction calculation with a set of policies with effective dates no more than six months prior to the date of filing.

(5) The annual corrections described in subdivision (c) of this Section shall apply to each individual coverage or combination of coverages as described in Section 2632.8(a).

(6) The annual corrections described in subdivision (c) of this Section shall apply to the factor weights of each optional rating factor, as listed in Section 2632.5(d).

(7) The factor weights for the three mandatory rating factors in each filing shall be in the order specified in Section 2632.8(d).

(8) An insurer may choose to make more than one class plan filing during each annual period, however, the first annual filing must correct at least 15% of the current amount of non–compliance as provided in subdivision (c) of this Section. An insurer may also choose to achieve full compliance at any date prior to the end of the two–year transition period.

(d) Any class plan change approved by the Commissioner shall be implemented no later than 90 days after the date the plan is approved by the Commission. Implementation, as referred to herein, shall apply to both the issuance of new policies and renewals, and the implementation shall not result in unfair discrimination between insureds that are issued new and renewal policies.

(e) The Commissioner shall approve or reject a class plan submitted by an insurer within 90 days of the date a completed class plan application is received by the Commissioner.

(f) An insurer whose class plan has been rejected by the Commissioner may, within 30 days of the date of such rejection, request a hearing before the Commissioner. Such hearing shall be conducted in compliance with California Insurance Code section 1861.08, and the insurer requesting such hearing shall have the burden of proving that the rejected class plan complied with all applicable statutes and regulations.

(g) Any change to an approved class plan or values assigned to the rating factors, and any change to the values assigned to the make, model, value, cost of repair, or auto symbol for the insured vehicles requires the prior approval of the Commissioner. Proposed changes must be submitted with a class plan application.

(h) Every insurer that uses auto symbols for any vehicle must submit its methodology for determining such symbols, and all values and relativities associated therewith, to the Commissioner for approval prior to use. Any subsequent changes in methodology must also be submitted to the Commissioner for approval prior to use. Further, every insurer that uses auto symbols must submit the following to the Commissioner, annually, on a date to be agreed upon between the insurer and the Commissioner, or if no agreement is reached, on a date to be specified by the Commissioner:

(1) all auto symbols, and the values and relativities associated therewith, that the insurer proposes to use during the ensuing 12 months. For a new auto model which becomes available after the date upon which the submission is made, the insurer shall assign a symbol according to the in-

surer's approved symbol methodology, and the insurer may then commence using the symbol. Such symbols shall be submitted for approval to the Commissioner with the insurer's next annual submission of all auto symbols.

(2) data sufficient to support any proposed changes in auto symbols, or changes in the values or relativities associated with any auto symbols, including but not limited to, damageability studies;

(3) data sufficient to show the anticipated impact of any class changes in auto symbols upon the total revenue generated by the insurer's private automobile insurance business.

(i) Every insurer that does not use auto symbols, but which uses make, model, value, cost of repair, as factors in determining rates and premiums for private passenger automobile insurance must submit its methodology for determining such factors, and all values and relativities associated therewith, to the Commissioner for approval prior to use. Any subsequent changes in methodology must also be submitted to the Commissioner for approval prior to use. Further, every insurer that uses such factors must submit the following to the Commissioner, annually, on a date to be agreed upon between the insurer and the Commissioner, or if no agreement is reached, on a date to be specified by the Commissioner:

(1) All factors, and the values and relativities associated therewith, that the insurer proposes to use during the ensuing 12 months. For a new auto model which becomes available after the date upon which the submission is made, the insurer shall determine factors according to the insurer's approved methodology, and the insurer may the commence using the factors. Such factors shall be submitted for approval to the Commission with the insurer's next annual submission of all factors;

(2) data sufficient to support any proposed changes in such factors, or changes in the values or relativities associated therewith, including, but not limited to, damageability studies;

(3) data sufficient to show the anticipated impact of any changes in factors upon the total revenue generated by the insurer's private passenger automobile insurance business.

(j) Insurers may use auto symbols determined by advisory organizations that are in compliance with Insurance Code Section 1855, *et seq.* In lieu of the requirements of subpart (h) above, insurers shall submit to the Commissioner, annually, on a date to be agreed upon between the insurer and the Commissioner, or if no agreement is reached, on a date to be specified by the Commissioner, the following:

(1) a statement that the insurer proposes to use the symbols of an advisory organization;

(2) the identity of the advisory organization;

(3) sufficient information to identify the auto symbols of the organization that the insurer proposes to use.

NOTE: Authority cited: Section 1861.02, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805. Reference: Section 1861.02, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer and new section transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.
2. New subsection (a) and amendment of NOTE filed 7–5–96; operative 8–4–96 (Register 96, No. 27).
3. Amendment of subsections (a), (a)(3) and (c)–(d) and amendment of NOTE filed 7–14–2006; operative 8–13–2006 (Register 2006, No. 28).

Article 4. Good Driver Discount Policy

§ 2632.12. Good Driver Discount.

(a) Every insurer offering a policy of automobile insurance shall set its rates so that a good driver, as defined in Section 1861.025 of the California Insurance Code, shall be charged a rate that is at least 20 percent less than the lowest rate available to a comparable driver who is not a good driver. The good driver discount must be applied after the total premium is developed under the class plan, including any policy fees that apply to the issuance of the policy.

(b) If a good driver as determined pursuant to California Insurance Code Section 1861.025 is not eligible to purchase a good driver discount policy because of the driving safety record or years of driving experience of any other person, then the good driver shall be eligible to purchase a good driver discount policy which excludes such other persons from coverage.

NOTE: Authority cited: Sections 1861.02, 1861.025, 12921 and 12926, Insurance Code. Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including new article 4 and repealer and new section transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.
2. Editorial correction of subsection lettering (Register 97, No. 19).

§ 2632.12.1. Use of Rates Pursuant to Approved Rating Plans.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code; and *Calfarm Ins. Co.* v. *Deukmejian* 48 Cal.3d 805 (1989). Reference: Section 1861.02, Insurance Code.

HISTORY

1. New section filed 12–14–90 as an emergency; operative 12–14–90 (Register 91, No. 6). A Certificate of Compliance must be transmitted to OAL by 4–15–91 or emergency language will be repealed by operation of law on the following day.
2. Amendment filed 3–18–91 as an emergency; operative 3–18–91 (Register 91, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–16–91 or emergency language will be repealed by operation of law on the following day.
3. Readoption of 3–18–91 emergency order filed 3–29–91 as an emergency; operative 3–29–91 (Register 91, No. 21). A Certificate of Compliance must be transmitted to OAL by 7–29–91 or emergency language will be repealed by operation of law on the following day.
4. Readoption of emergency order filed 7–26–91 as an emergency; operative 7–26–91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11–25–91 or emergency language will be repealed by operation of law on the following day.
5. Readoption of emergency order filed 11–27–91 as an emergency; operative 11–27–91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3–26–92 or emergency language will be repealed by operation of law on the following day.
6. Readoption of emergency order filed 3–25–92; operative 3–25–92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7–23–92 or emergency language will be repealed by operation of law on the following day.
7. Readoption of emergency order filed 7–22–92 as an emergency; operative 7–22–92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11–19–92 or emergency language will be repealed by operation of law on the following day.
8. Readoption of emergency order filed 11–19–92 as an emergency; operative 11–19–92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3–19–92 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order including amendment of subsection (b) filed 3–26–93 as an emergency; operative 3–26–93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7–26–93 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order filed 7–22–93 as an emergency; operative 7–22–93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–19–93 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order filed 11–18–93 as an emergency; operative 11–18–93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–94 or emergency language will be repealed by operation of law on the following day.
12. Readoption of emergency order filed 3–17–94 as an emergency; operative 3–17–94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–14–94 or emergency language will be repealed by operation of law on the following day.
13. Certificate of Compliance as to 3–17–94 order including repealer transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34).

§ 2632.13. Eligibility to Purchase Good Driver Discount Policy and Guidelines for Determination of "Principally At–Fault."

(a) In determining a driver's qualification to purchase a good driver discount policy pursuant to California Insurance Code Section 1861.025, an insurer shall determine the driver's violation points and principally at–fault accidents as set forth in this section. This section shall also apply in

determining whether a driver was principally at–fault in an accident for the purpose of determining the driver's safety record (First Mandatory Factor).

(b) Violation point counts and principally at–fault accidents shall be determined as follows:

(1) The insurer may count one violation point count for each violation point count which has been assessed by the California Department of Motor Vehicles under California Vehicle Code section 12810, Subsections (a), (b), (c), (d), (e), (g) and (h), for traffic violation convictions with conviction dates not more than three years preceding the effective or renewal date of the policy, and which have not been made confidential under the California Vehicle Code;

(2) For violations not occurring in California, the insurer may count one violation point count for each violation point count which would have been counted under subsection (1) above had the violation occurred in California. Violation points shall not be counted pursuant to this Subsection if violation points were counted for the violation pursuant to Subsection (b)(1) above;

(3) The insurer may count one violation point if a driver was involved in an accident which resulted only in damage to property if the driver was principally at fault in the accident, as defined in Subsection (c). A driver may be determined to be principally at fault for such an accident where the accident was a solo vehicle accident, subject to the exceptions set forth in subsection (d).

(c) a driver may be considered to be principally at fault in an accident if the driver's actions or omissions were at least 51 percent of the proximate cause of the accident, subject to the exceptions set forth in Subsection (d), and, in accidents not resulting in death, if the damage to the property of any one person caused by the accident exceeded $750.00.

(d) A driver shall not be considered to be principally at–fault if the accident occurred under any of the following circumstances:

(1) The vehicle was lawfully parked at the time of the accident. A vehicle rolling from a parked position shall not be considered to be lawfully parked, but shall be considered as in the operation of the last operator;

(2) The vehicle was struck in the rear by another vehicle, and the driver has not been convicted of a moving traffic violation in connection with the accident;

(3) The driver was not convicted of a moving traffic violation and the operator of another vehicle involved in the accident was convicted of a moving traffic violation;

(4) The driver's vehicle was damaged as a result of contact with a vehicle operated by a "hit and run" operator of another vehicle and the accident was reported to legal authorities within a reasonable time after the accident;

(5) The accident resulted from contact with animals, birds, or falling objects;

(6) The driver was responding to a call of duty as a paid or volunteer member of any police or fire department, first aid squad, or of any law enforcement agency, while performing any other governmental function in a public emergency.

(7) The accident was a solo vehicle accident that was principally caused by a hazardous condition of which a driver, in the exercise of reasonable care, would not have noticed (for example, "black ice.")

(e) An insurer providing insurance coverage at the time of an accident shall not make a determination that a driver was principally at–fault for an accident, other than an indisputably solo vehicle accident and which is not of the type specified in subpart (d), unless the insurer first does the following:

(1) the insurer shall make an investigation of the accident;

(2) the insurer shall provide written notice to the insured of the result of such investigation, including any determination that the insured was principally at fault. The notice shall specify the basis of any determination that a driver was principally at fault. The notice shall advise the insured of the right to reconsideration of the determination of fault, as set forth for in Subsection (e)(3);

(3) Within 30 days of receipt by the insured of a written notice required by Subsection (e)(2), the insured may request reconsideration of the insurer's determination that the insured was principally at–fault. The insurer shall provide written notice of its decision upon reconsideration within 30 days of the insured's request therefor and the notice shall state the reasons for its decision upon reconsideration. The reconsideration shall be made by an employee or agent of the insurer other than the employee or agent who made the determination being reconsidered. The right to reconsideration set forth herein shall not affect any other rights of the insured.

(f) If a driver had insurance that provided coverage for an accident, a subsequent insurer which did not provide coverage at the time of the accident and to whom an application for the issuance of a policy of insurance is made, or from whom a renewal policy is offered, may not consider the driver to be principally at–fault for the accident unless the following circumstances apply:

(1) if the insurer that provided coverage at the time of the accident charged the driver with a violation point for the accident in accordance with this Section, or the predecessor of this Section; or,

(2) if the driver was not covered by an automobile insurance policy delivered or issued for delivery in California and issued and in force pursuant to the laws of California at the time of the accident, and the insurer determines that the driver was principaly at–fault as provided for in Subsection (g); or,

(3) if the insurer of the driver at the time of the accident did not have notice of the accident and no other insurer of any person involved in the accident made a determination that any other driver was at least 51% of the proximate cause of the accident, and the insurer determines that the driver was principally at fault as provided for in Subsection (g).

(g) If a driver did not have insurance that provided coverage for an accident, and if no other insurer of any person involved in the accident made a determination that any other driver was at least 51% of the proximate cause of the accident, an insurer to whom an application for the issuance or renewal of a policy of automobile insurance is made may consider a driver to be principally at–fault if the insurer has sufficient information to make that determination. For the purpose of this Subsection, the following shall apply:

(1) the insurer shall make reasonable efforts to obtain information concerning the accident from any insurer of a person involved in the accident;

(2) the insurer shall request sufficient information from the driver;

(3) upon reasonable request by the insurer, a driver shall provide sufficient information concerning the accident to the insurer for the insurer to determine whether the driver was principally at–fault. If the driver fails or refuses to provide such information, then the insurer may count a violation point for the accident or may consider the driver to be principally at–fault.

(h) An insurer that has made a determination that its insured was principally at–fault in an accident shall not refuse to disclose that determination to any person involved in that accident, to any person legally responsible for damages resulting from that accident, or to an insurer or prospective insurer of any such person. The requirement for disclosure shall pertain only to the ultimate determination of its insured's fault, and disclosure shall not be required of any other information in its possession or any determination of fault of any person other than the insured.

(i) Notwithstanding any other provision of this section, in determining a driver's at–fault accident history, a driver's declaration, under penalty of perjury, attesting to his or her at–fault accident history, shall be sufficient proof of that accident history in the absence of contrary information from an independent source. If an insurer discovers that the declaration contains a fraudulent or material misrepresentation, the insurer may use that information to rate the policy, may cancel the policy pursuant to California Insurance Code sections 661 and 1861.03(c)(1) and take any other action authorized by law.

Nothing in this subdivision shall prevent an insurer from using information available from the public record of traffic violation convictions as set forth in section 2632.5(c)(1)(A), principally at-fault accidents as set forth in this section, or information from a subscribing loss underwriting exchange carrier. Nothing in this subdivision shall prevent an insurer from asking follow-up questions about the information contained in the declaration, and nothing in this subdivision shall authorize a driver to refuse to answer a reasonable follow-up question.

If an insurer discovers contrary information from an independent source disputing the driver's declaration, the insurer shall so notify the driver within ten days of discovery of the contrary information and allow the driver at least five days to provide a response.

Within 45 days of the effective date of this subsection, each insurer writing private passenger automobile insurance shall file with the Department's Rate Filing Bureau (1) evidence demonstrating its compliance with this subsection or (2) a plan demonstrating how it will comply with this subsection. If the insurer files a plan demonstrating how it will comply with this subsection, it shall, within 120 days of the effective date of this subsection, file class plan and/or rate applications which are in compliance with this subsection. For insurers whose plan requires the Commissioner's prior approval of a revised class plan and/or rate application to achieve compliance, the insurer shall implement the revised class plan and/or rate application in accordance with the terms of the Commissioner's approval of the revised class plan and/or rate application.

(j) In determining eligibility to purchase a good driver discount policy, the requirement that the driver have been licensed to drive a motor vehicle for the previous three years shall mean that the driver has been licensed to drive in any jurisdiction.

NOTE: Authority cited: Sections 1861.02, 1861.025, 12921 and 12926, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* 48 Cal.3d 805 (1989). Reference: Sections 488.5, 1861.02 and 1861.025, Insurance Code; and Sections 12810 and 16000, Vehicle Code.

HISTORY

1. Certificate of Compliance as to 3-17-94 order including repealer of article 4 heading and repealer and new section filed transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34). For prior history, see Register 94, No. 11.
2. New subsection (i) and subsection relettering filed 10-31-2002; operative 11-30-2002 (Register 2002, No. 44).
3. Change without regulatory effect amending subsection (c) and NOTE filed 12-5-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 49).
4. Amendment of subsections (e)(2)-(3) filed 10-4-2004; operative 11-3-2004 (Register 2004, No. 41).

§ 2632.13.1. Guidelines for Determination of "Principally at Fault" Under California Insurance Code Section 1861.025.

NOTE: Authority cited: Sections 1861.025, 12921 and 12926, Insurance Code. Reference: Section 1861.025, Insurance Code; and Section 12810, Vehicle Code.

HISTORY

1. New section filed 2-13-90 as an emergency; operative 2-13-90 (Register 90, No. 8). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 6-13-90.
2. New section refiled 6-13-90 as an emergency; operative 6-13-90 (Register 90, No. 32). A Certificate of Compliance must be transmitted to OAL by 10-11-90 or emergency language will be repealed by operation of law on the following day.
3. New section filed 8-6-90 as an emergency; operative 8-6-90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12-4-90 or emergency language will be repealed by operation of law on the following day.
4. Readoption of 8-6-90 emergency order filed 11-30-90 as an emergency; operative 11-30-90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4-1-91 or emergency language will be repealed by operation of law on the following day.
5. Readoption of emergency order filed 7-26-91 as an emergency; operative 7-26-91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11-25-91 or emergency language will be repealed by operation of law on the following day.
6. Readoption of emergency order filed 11-27-91 as an emergency; operative 11-27-91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3-26-92 or emergency language will be repealed by operation of law on the following day.
7. Readoption of emergency order filed 3-25-92; operative 3-25-92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7-23-92 or emergency language will be repealed by operation of law on the following day.
8. Readoption of emergency order filed 7-22-92 as an emergency; operative 7-22-92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11-19-92 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order filed 11-19-92 as an emergency; operative 11-19-92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3-19-92 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order filed 3-26-93 as an emergency; operative 3-26-93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7-26-93 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order filed 7-22-93 as an emergency; operative 7-22-93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11-19-93 or emergency language will be repealed by operation of law on the following day.
12. Readoption of emergency order filed 11-18-93 as an emergency; operative 11-18-93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3-18-94 or emergency language will be repealed by operation of law on the following day.
13. Readoption of emergency order filed 3-17-94 as an emergency; operative 3-17-94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7-14-94 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 3-17-94 order including repealer transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34).

§ 2632.14. Policies Offered to Good Drivers and Nondiscrimination.

(a) Except as provided by Insurance Code section 1861.15(d) every insurer required to offer a good driver discount policy of automobile insurance pursuant to section 1861.02(b) of the California Insurance Code shall offer to sell each of the following to a good driver:

(1) a good driver discount policy that contains only the minimum limits of liability coverage specified in Section 16056 of the California Vehicle Code;

(2) a good driver discount policy that contains comprehensive coverage or automobile collision coverage, or both of such coverages, in addition to automobile liability coverage;

(3) a good driver discount policy that contains any of the limits of coverage, the types of coverage, and amounts of deductibles that the insurer offers to sell to the public.

(b) Insurers required to offer good driver discount policies pursuant to section 1861.02(b) of the California Insurance Code shall offer and sell good driver discount policies under the same terms and conditions and with the same options and services that the insurer offers and sells to the public for any other automobile insurance policy. The foregoing includes but is not limited to terms for payment of premiums and the payment of commissions to agents.

NOTE: Authority cited: Sections 1861.02, 1861.15, 12921 and 12926, Insurance Code. Reference: Section 1861.02, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3-17-94 order including repealer and new section transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

§ 2632.14.1. Policies Offered to Good Drivers and Nondiscrimination.

NOTE: Authority cited: Sections 1861.02, 1861.15, 12921 and 12926, Insurance Code. Reference: Section 1861.02, Insurance Code.

HISTORY

1. New section filed 3-12-90 as an emergency; operative 3-12-90 (Register 90, No. 12). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 7-10-90.
2. New section filed 7-5-90 as an emergency readoption; operative 7-11-90 (Register 90, No. 35). A Certificate of Compliance must be transmitted to OAL by 11-8-90 or emergency language will be repealed by operation of law on the following day.
3. New section filed 8-6-90 as an emergency; operative 8-6-90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12-4-90 or emergency language will be repealed by operation of law on the following day.
4. Readoption of 8-6-90 emergency order filed 11-30-90 as an emergency; operative 11-30-90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4-1-91 or emergency language will be repealed by operation of law on the following day.

5. Editorial correction restoring HISTORY 1 dropped in printing (Register 91, No. 15).
6. Readoption of 11-30-90 emergency order, including amendment of subsection (a), filed 3-29-91 as an emergency; operative 3-29-91 (Register 91, No. 21). A Certificate of Compliance must be transmitted to OAL by 7-29-91 or emergency language will be repealed by operation of law on the following day.
7. Readoption of emergency order filed 7-26-91 as an emergency; operative 7-26-91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11-25-91 or emergency language will be repealed by operation of law on the following day.
8. Readoption of emergency order filed 11-27-91 as an emergency; operative 11-27-91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3-26-92 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order filed 3-25-92; operative 3-25-92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7-23-92 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order filed 7-22-92 as an emergency; operative 7-22-92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11-19-92 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order filed 11-19-92 as an emergency; operative 11-19-92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3-19-92 or emergency language will be repealed by operation of law on the following day.
12. Readoption of emergency order filed 3-26-93 as an emergency; operative 3-26-93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7-26-93 or emergency language will be repealed by operation of law on the following day.
13. Readoption of emergency order filed 7-22-93 as an emergency; operative 7-22-93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11-19-93 or emergency language will be repealed by operation of law on the following day.
14. Readoption of emergency order filed 11-18-93 as an emergency; operative 11-18-93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3-18-94 or emergency language will be repealed by operation of law on the following day.
15. Readoption of emergency order filed 3-17-94 as an emergency; operative 3-17-94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7-14-94 or emergency language will be repealed by operation of law on the following day.
16. Certificate of Compliance as to 3-17-94 order including repealer transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34).

§ 2632.14.2. Good Driver Discount Policies from Companies Within Insurance Groups.

NOTE: Authority cited: Sections 1861.02, 12921 and 12926, Insurance Code. Reference: Section 1861.02, Insurance Code.

HISTORY

1. New section filed 3-12-90 as an emergency; operative 3-12-90 (Register 90, No. 12). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 7-10-90.
2. New section filed 7-5-90 as an emergency readoption; operative 7-11-90 (Register 90, No. 35). A Certificate of Compliance must be transmitted to OAL by 11-8-90 or emergency language will be repealed by operation of law on the following day.
3. New section filed 8-6-90 as an emergency; operative 8-6-90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12-4-90 or emergency language will be repealed by operation of law on the following day.
4. Readoption of 8-6-90 emergency order filed 11-30-90 as an emergency; operative 11-30-90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4-1-91 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction restoring HISTORY 1 dropped in printing (Register 91, No. 15).
6. Readoption of 11-30-90 emergency order, including amendment to Authority cites, filed 3-29-91 as an emergency; operative 3-29-91 (Register 91, No. 21). A Certificate of Compliance must be transmitted to OAL by 7-29-91 or emergency language will be repealed by operation of law on the following day.
7. Readoption of emergency order filed 7-26-91 as an emergency; operative 7-26-91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11-25-91 or emergency language will be repealed by operation of law on the following day.
8. Readoption of emergency order filed 11-27-91 as an emergency; operative 11-27-91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3-26-92 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order filed 3-25-92; operative 3-25-92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7-23-92 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order filed 7-22-92 as an emergency; operative 7-22-92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11-19-92 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order filed 11-19-92 as an emergency; operative 11-19-92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3-19-92 or emergency language will be repealed by operation of law on the following day.
12. Readoption of emergency order filed 3-26-93 as an emergency; operative 3-26-93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7-26-93 or emergency language will be repealed by operation of law on the following day.
13. Readoption of emergency order filed 7-22-93 as an emergency; operative 7-22-93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11-19-93 or emergency language will be repealed by operation of law on the following day.
14. Readoption of emergency order filed 11-18-93 as an emergency; operative 11-18-93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3-18-94 or emergency language will be repealed by operation of law on the following day.
15. Readoption of emergency order filed 3-17-94 as an emergency; operative 3-17-94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7-14-94 or emergency language will be repealed by operation of law on the following day.
16. Certificate of Compliance as to 3-17-94 order including repealer transmitted to OAL 7-12-94 and filed 8-23-94; operative 9-22-94 (Register 94, No. 34).

§ 2632.14.3. Letter of Refusal for Good Driver.

(a) As used in Insurance Code section 658, "refuses to accept an applicant" means a failure or refusal, either by an insurer or any of its appointed agents, to allow an applicant for a Good Driver discount policy, as defined in Insurance Code section 1861.025, to complete an application for insurance, or to respond to a telephone inquiry about obtaining insurance coverage within three business days of receipt of the inquiry. It also means any attempt or act on the part of an insurer or any of its appointed agents to dissuade an applicant for a Good Driver discount policy from completing an application for insurance, other than statements which inform the applicant about how he or she can obtain insurance on more advantageous terms from another insurer.

(b) As used in Insurance Code section 658, "refuses to issue a good driver discount policy" includes an insurer's failure or refusal to bind coverage within fifteen business days of the date of receipt, by the insurer or any of its appointed agents, of the insurer's application completed by or on behalf of the applicant. The fifteen business day time period shall begin from the date either the insurer or any of its appointed agents receives the completed application, whichever date is earliest. The fifteenth day of the fifteen business day time period shall be deemed the date on which the insurer "refuses to issue a good driver discount policy."

(c) When an insurer's appointed agent refuses to accept an applicant for a Good Driver discount policy or refuses to issue a Good Driver discount policy when written application has been made by a Good Driver, that agent shall provide the written statement required by Insurance Code section 658 explaining the reason for the refusal.

(d) As used in Insurance Code section 658, the requirements that an insurer "shall furnish the applicant for insurance a written statement within 10 days of the refusal" means that the insurer or agent shall provide the written statement to the applicant by personal delivery within ten calendar days of the refusal date, or if the written statement is provided by mail, shall mail the written statement to the applicant by first class U.S. mail postage prepaid within ten calendar days of the refusal date.

(e) As used in Insurance Code section 658, the requirement that the written statement explain the "reason or reasons relied upon for denying insurance coverage" means that the written statement shall set forth in detail all of the facts on which the refusal is based. Mere conclusory statements unsupported by a statement of facts pertaining to the particular applicant shall be insufficient to satisfy the requirements of the statute.

(f) Every applicant who meets the criteria for purchase of a Good Driver discount policy shall be provided, at the time he or she first inquires about obtaining an automobile liability policy from the insurer or any of its appointed agents, with the following statement:

An insurer which refuses to provide coverage to an applicant who is a "Good Driver" must provide the applicant with a written statement of

the reasons it denied coverage. In general, under California law a Good Driver is a person who has not had more than one violation point or more than one at-fault accident resulting in only property damage in the last three years.

Every such applicant inquiring about coverage in person or by mail shall be provided with a written copy of the statement, which shall appear in at least ten-point type. Every such applicant inquiring about coverage by telephone shall be provided with the statement by telephone.

(g) This section shall apply to applications for private passenger automobile insurance only.

(h) This section shall apply only to persons qualified to purchase a Good Driver Discount policy as defined in Insurance Code section 1861.025.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code; *CSAA v. Garamendi* (1992) 6 Cal.App.4th 1409. Reference: Sections 658, 1861.02 and 1861.025, Insurance Code.

HISTORY

1. New section filed 4-5-94; operative 5-5-94 (Register 94, No. 14).

§ 2632.15. Data Retention.

(a) Every insurer offering or issuing a policy of automobile insurance shall collect and retain the data listed in this subsection. All data requirements apply only to an insurer's direct business. If an insurer does not in any way use or collect an item listed in subsection (3) below for any individual insured, they are not required to collect and report the item. This file will be referred to as the "Current File". Insurers are required to collect and retain data on the listed factors, they are not required to use these factors in calculating premiums.

(1) All data must be kept in a computer file that allows for the insurer to place the data on computer media (tape, cartridge or disk). All data must be recorded in a raw, ungrouped format in a manner specified by the Commissioner.

(2) Every insurer shall begin collecting the data for current policy holders, beginning with all renewals effective on or after 180 days after the effective date of these regulations.

(3) The following items shall be kept for every currently insured vehicle:

(A) The latest effective or renewal date of the policy;

(B) The number of drivers assigned to this vehicle;

(C) The following information for the rated driver on this vehicle (as of the last renewal date for this policy or date of latest coverage or vehicle change). To the extent that it is available, all violation and accident data shall cover a minimum of six years.

1. The total number of convictions.
2. The date and California vehicle code section (or its equivalent) of each violation.
3. The total number of at-fault BI accidents with over $500 damage.
4. The date of each at-fault BI accidents with over $500 damage.
5. The total number of at-fault non-BI accidents with over $500 damage.
6. The date of each at-fault non-BI accidents with over $500 damage.
7. Number of years since the last at-fault BI accident with over $500 in damage.
8. Number of years since the last at-fault non-BI accident with over $500 in damage.
9. Number of years since the last convictions.
10. Gender.
11. Martial status (legally married, single or widowed only).
12. Percentage use this driver.
13. Years licensed to drive.
14. Age.
15. Smoker status.
16. Academic status. Indicator to describe if the driver is a student and if so if they qualify for a good student discount.
17. Senior defensive driver discount eligibility.
18. Driver training status.
19. Any other driver related factors the Commissioner has approved and the insurer uses.

(D) The same information listed under (C) shall also be kept for every driver assigned to this vehicle. Data for each driver shall only be kept for one vehicle, unless there are excess vehicles in which case the data under (C) shall include the data for the driver that puts the most mileage on the excess vehicle.

(E) Additional vehicle indicator. This is used for insureds that have more vehicles than drivers where there is no rated driver.

(F) Zip Code of the vehicle's location.

(G) Type of use indicator (pleasure only, business, commute, etc.).

(H) Weekly commute miles.

(I) Vehicle model year.

(J) Vehicle value (price group) code.

(K) Vehicle type; auto, light pickup truck, van, heavy truck, Motorcycle, antique auto or other.

(L) Vehicle performance type.

(M) Limits and deductibles, separately for all coverages.

(N) Good driver discount status.

(O) Multi-vehicle household.

(P) The number of semi-annual renewals for this policy.

(Q) Vehicle safety and anti-theft equipment, including but not limited to:

1. Anti-lock brake, including number of wheels covered;
2. Air bags, including number and location;
3. Automatic seat belts;
4. Anti-theft devices, including type;
5. Vehicle garaging status.

(R) Premiums, separately for each coverage.

(S) Actual previous years mileage, rounded to the nearest hundred miles.

(T) Estimated current years mileage for the 12 month period beginning with the start of this policy, rounded to the nearest hundred miles.

(U) Any other vehicle related factors the Commissioner has approved and the insurer uses.

(V) Any other factor the Commissioner has adopted by regulation.

(W) VIN.

(X) Policy number and vehicle number.

(4) Insurers shall maintain these data so that they are able to provide them to the Commissioner within three months of receipt of a request for the data.

(b) Every insurer issuing a policy of automobile insurance shall maintain historical underwriting, loss and exposure data for each calendar year for each of the latest four years for every insured vehicle. All data requirements apply only to an insurer's direct business. If an insurer does not in any way use or collect an item listed in subsection (6) and (7) below for any individual insured, they are not required to collect and report the item. This data shall be kept in two files with records kept by each vehicle. One file will be referred to as the "Historical Exposure File", and the other file will be referred to as the "Historical Losses File".

(1) All data must be kept in a computer file that allows for the insurer to place each Calendar year's data on computer media (tape, cartridge or disk). All data must be recorded in a raw, ungrouped format in a manner specified by the Commissioner.

(2) The data shall be kept for a minimum of four years after the end of each calendar year.

(3) Every insurer shall begin collecting the data for all policies in effect beginning the first of the quarter after the effective date of these regulations.

(4) All loss and loss reserve information shall reflect the loss and loss reserve estimates as of the latest calendar quarter. The data on losses occurring four years ago shall reflect the reserve estimates as of the latest quarter. All loss data shall be based on claims received by the insurer for that coverage as the consequence of a single incident regardless of the number of claimants.

(5) In the event of a change in any risk related factors, multiple records per vehicle shall be generated for the calendar year. A new record shall be generated for the "Historical Exposure File" each time any of the data in (a)(3)(C) through (V) changes.

(6) The "Historical Exposure File" shall contain the following items for every insured vehicle for all exposure during each calendar year:

(A) The data item listed in Section 2632.15(a);

(B) The termination date of the policy or a code indicating the policy is still in effect;

(C) Earned premium listed separately for each coverage;

(D) Earned exposure listed separately for each coverage.

(7) The "Historical Losses File" shall contain the following information for each claim as a result of incidents occurring during the calendar year:

(A) Policy number and vehicle number. These numbers must match the policy number and vehicle number in the "Historical Exposure File" for the vehicle to which the loss is assigned;

(B) Date of accident;

(C) Number of claimants;

(D) Total dollar amount of incurred losses listed separately by coverage and including the latest estimate of the ultimate loss reserves and loss adjustment reserves as described in Section 2632.15(b) Paragraph (4).

(E) Capped losses for bodily injury liability coverages.

(F) Closed claim indicator by coverage.

(8) Insurers shall maintain these data so that they are able to provide them to the Commissioner within three months of receipt of a request for the data.

NOTE: Authority cited: Sections 1861.02 and 1861.03, Insurance Code; and *Calfarm Insurance v. Deukmejian* (1989) 48 Cal.3d 805. Reference: Sections 1861.02 and 1861.03, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer of article 5 heading and repealer and new section heading transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.
2. New section filed 7–5–96; operative 8–4–96 (Register 96, No. 27).

§ 2632.16. Severability.

If the provisions of this Subchapter, or the application of any provisions of this Subchapter to any person or to any circumstances is held invalid, that invalidity shall not affect other provisions or applications of these regulations which can be given effect without the invalid provisions or application, and to this end the provisions of these regulations are severable

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.02, 1861.025, 1861.15 and 11628, Insurance Code.

HISTORY

1. Certificate of Compliance as to 3–17–94 order including repealer and new section transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34). For prior history, see Register 94, No. 11.

§ 2632.17. Effective Date and Interim Rates.

NOTE: Authority cited: Sections 1861.02, 1861.05, 12921 and 12926, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* 48 Cal.3d 805 (1989). Reference: Sections 1861.02 and 1861.05, Insurance Code.

HISTORY

1. New section filed 12–15–89 as an emergency; operative 12–15–89 (Register 90, No. 3). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4–16–90.

[The next page is 728.17.]

2. New section filed 4–13–90 as an emergency; operative 4–15–90 (Register 90, No. 17). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 8–13–90.
3. New section filed 8–6–90 as an emergency; operative 8–6–90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12–4–90 or emergency language will be repealed by operation of law on the following day.
4. New section refiled 8–13–90 as an emergency; operative 8–13–90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12–12–90 or emergency language will be repealed by operation of law on the following day.
5. Readoption of 8–6–90 emergency order filed 11–30–90 as an emergency; operative 11–30–90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4–1–91 or emergency language will be repealed by operation of law on the following day.
6. Readoption of 8–13–90 emergency order filed 12–12–90 as an emergency; operative 12–12–90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4–11–91 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of HISTORY 6 correcting operative date (Register 91, No. 21).
8. Readoption of 11–30–90 emergency order filed 3–29–91 as an emergency; operative 3–29–91 (Register 91, No. 21). A Certificate of Compliance must be transmitted to OAL by 7–29–91 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order filed 7–26–91 as an emergency; operative 7–26–91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11–25–91 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order filed 11–27–91 as an emergency; operative 11–27–91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3–26–92 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order, including repealer of italicized text, filed 3–25–92; operative 3–25–92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7–23–92 or emergency language will be repealed by operation of law on the following day.
12. Editorial correction restoring article 6 heading (Register 92, No. 20).
13. Readoption of emergency order filed 7–22–92 as an emergency; operative 7–22–92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11–19–92 or emergency language will be repealed by operation of law on the following day.
14. Readoption of emergency order filed 11–19–92 as an emergency; operative 11–19–92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3–19–92 or emergency language will be repealed by operation of law on the following day.
15. Readoption of emergency order filed 3–26–93 as an emergency; operative 3–26–93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7–26–93 or emergency language will be repealed by operation of law on the following day.
16. Readoption of emergency order filed 7–22–93 as an emergency; operative 7–22–93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–19–93 or emergency language will be repealed by operation of law on the following day.
17. Readoption of emergency order filed 11–18–93 as an emergency; operative 11–18–93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–94 or emergency language will be repealed by operation of law on the following day.
18. Readoption of emergency order filed 3–17–94 as an emergency; operative 3–17–94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–14–94 or emergency language will be repealed by operation of law on the following day.
19. Certificate of Compliance as to 3–17–94 order including repealer of article 6 heading and section transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34).

§ 2632.18. Severability.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code. Reference: Sections 1861.02, 1861.025, 1861.03 and 1861.05, Insurance Code.

HISTORY

1. New section filed 4–13–90 as an emergency; operative 4–15–90 (Register 90, No. 17). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 8–13–90.
2. New section filed 8–6–90 as an emergency; operative 8–6–90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12–4–90 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 8–13–90 as an emergency; operative 8–13–90 (Register 90, No. 43). A Certificate of Compliance must be transmitted to OAL by 12–12–90 or emergency language will be repealed by operation of law on the following day.
4. Readoption of 8–6–90 emergency order filed 11–30–90 as an emergency; operative 11–30–90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4–1–91 or emergency language will be repealed by operation of law on the following day.
5. Readoption of 8–13–90 emergency order filed 12–12–90 as an emergency; operative 12–12–90 (Register 91, No. 4). A Certificate of Compliance must be transmitted to OAL by 4–11–91 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 correcting operative date (Register 91, No. 21).
7. Readoption of 11–30–90 emergency order filed 3–29–91 as an emergency; operative 3–29–91 (Register 91, No. 21). A Certificate of Compliance must be transmitted to OAL by 7–29–91 or emergency language will be repealed by operation of law on the following day.
8. Readoption of emergency order filed 7–26–91 as an emergency; operative 7–26–91 (Register 92, No. 4). A Certificate of Compliance must be transmitted to OAL 11–25–91 or emergency language will be repealed by operation of law on the following day.
9. Readoption of emergency order filed 11–27–91 as an emergency; operative 11–27–91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 3–26–92 or emergency language will be repealed by operation of law on the following day.
10. Readoption of emergency order, including repealer of italicized text, filed 3–25–92; operative 3–25–92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 7–23–92 or emergency language will be repealed by operation of law on the following day.
11. Readoption of emergency order filed 7–22–92 as an emergency; operative 7–22–92 (Register 92, No. 30). A Certificate of Compliance must be transmitted to OAL 11–19–92 or emergency language will be repealed by operation of law on the following day.
12. Readoption of emergency order filed 11–19–92 as an emergency; operative 11–19–92 (Register 92, No. 47). A Certificate of Compliance must be transmitted to OAL 3–19–92 or emergency language will be repealed by operation of law on the following day.
13. Readoption of emergency order filed 3–26–93 as an emergency; operative 3–26–93 (Register 93, No. 13). A Certificate of Compliance must be transmitted to OAL 7–26–93 or emergency language will be repealed by operation of law on the following day.
14. Readoption of emergency order filed 7–22–93 as an emergency; operative 7–22–93 (Register 93, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–19–93 or emergency language will be repealed by operation of law on the following day.
15. Readoption of emergency order filed 11–18–93 as an emergency; operative 11–18–93 (Register 93, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–94 or emergency language will be repealed by operation of law on the following day.
16. Readoption of emergency order filed 3–17–94 as an emergency; operative 3–17–94 (Register 94, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–14–94 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 3–17–94 order including repealer transmitted to OAL 7–12–94 and filed 8–23–94; operative 9–22–94 (Register 94, No. 34).

§ 2632.19. Substantial Increase in Hazard Insured Against.

(a) For the purpose of cancellation or nonrenewal pursuant to Insurance Code Section 1861.03(c), none of the following events or characteristics constitutes a substantial increase in the hazard insured against:

(1) the physical or mental health of the either the insured or any principal or occasional driver of the insured vehicle, unless the Department of Motor Vehicles has suspended, revoked, or refused to issue a license pursuant to suspension of a license, the suspension is not removed prior to the time that the nonrenewal or cancellation of the policy becomes effective;

(2) a physical disability of the insured or any principal or occasional driver of the insured vehicle, unless the insured, principal or occasional driver has failed to comply with a requirement of the California Department of Motor Vehicles, or the appropriate agency in the state that has issued the driver's license for the insured, regarding vehicle equipment or modification of the vehicle;

(3) the occupation or change in the occupation of the insured or any principal or occasional driver of the insured vehicle;

(4) the age of the insured or any principal or occasional driver of the insured vehicle;

(5) the age of the insured vehicle;

(6) the cosmetic appearance of the insured vehicle. "Cosmetic appearance" means damage that does not affect the safe operation of the insured vehicle;

(7) the termination or other change in the relationship between the insurer and the insurer's agent that issued, renewed, serviced or was otherwise responsible in any manner for the insured's policy.

(8) addition, deletion, substitution or replacement of vehicle. Notwithstanding the foregoing, an insurer may cancel or nonrenew a policy under the following circumstances:

(A) for an insurer that does not insure motorcycles or motor–driven cycles, if a motorcycle or motor–driven cycle would be added to the policy, whether by substitution, replacement, or otherwise; or,

(B) for an insurer that does not insure four–wheeled private passenger automobiles, if a four–wheeled private passenger automobile would be added to the policy, whether by substitution, replacement or otherwise;

(9) except as provided for in subpart (b), change in the use of the vehicle.

(b) For the purpose of cancellation or nonrenewal pursuant to Insurance Code Section 1861.03(c), the following events or characteristics shall constitute a substantial increase in the hazard insured against:

(1) the refusal or failure by the insured to provide to the insurer, within 30 days after reasonable written request to the insured, information necessary to accurately underwrite or classify the risk. Every written request for information to an insured shall contain a prominent notice, in both English and Spanish, advising the insured that his or her failure to provide the requested information within the time required may result in the cancellation or nonrenewal of his or her policy;

(2) permissive use of the insured vehicle by persons other than the insured and principal or occasional drivers of the insured vehicle, to an extent that indicates regular use of the vehicle by such persons;

(3) the failure of the insured vehicle to comply with California or federal safety requirements if such failure is not removed prior to the time that the insurer's nonrenewal or cancellation of the policy becomes effective;

(4) the alteration of the insured vehicle in order to increase speed or acceleration capabilities which renders the insured vehicle unsafe in violation of California Vehicle Code Section 24002;

(5) suspension of the license of the insured if such suspension is not removed prior to the time that the insurer's nonrenewal or cancellation of the policy becomes effective. Notwithstanding the foregoing, a suspension shall not be grounds for cancellation or nonrenewal if it is based on the insurer's failure to make a filing required by the California Insurance or Vehicle Codes, and if a request for such a filing was made by the insured;

(6) revocation of the license of the insured for any reason other than an insurer's failure to make a filing required by the California Insurance Code.

(7) expiration of the license of the insured if the insured has not obtained a valid license prior to the time that the insurer's nonrenewal or cancellation of the policy becomes effective.

(8) change in the use of the insured vehicle to commercial use, if such a change in use is prohibited under the terms of the policy of insurance or binder issued to the policyholder.

(9) a conviction of any alcohol–related offense specified in Sections 23152; 23153; 23220; 23221; 23222; 23224; or 23226 of the California Vehicle Code, provided the person does not otherwise qualify to purchase a good driver discount policy pursuant to Section 1861.025.

(c) For the purpose of nonrenewal pursuant to Insurance Code Section 1861.03(c), the following circumstances shall constitute a substantial increase in the hazard insured against:

(1)(A) the insured or principal or occasional driver of the insured vehicle has been assessed a total of three or more violation points under Section 2632.13 within the preceding 36 months. For the purpose of this subpart, traffic violation points may be counted only for violations that have conviction dates not more than 36 months preceding the renewal date of the policy; and

(B) at the time of the expiration of the insured's current policy, the insured is not eligible under the insurer's then–current underwriting rules to purchase a policy of private passenger automobile insurance from the insurer;

(2) the assessment of two points by the insurer under Section 2632.13 for the insured or any principal or occasional driver of the insured vehicle, as a result of a violation of the California Vehicle Code for which two points are assessed under California Vehicle Code Section 12810. For the purpose of this subpart, traffic violation points may be counted only for violations that have conviction dates not more than 36 months preceding the renewal date of the policy.

(d) For the purpose of Subsection (c)(1) only, an insurer may count two violation points for each accident in which, in accordance with Section 2632.13, the insured or any principal or occasional driver of the insured vehicle was determined to be principally at fault and which resulted in bodily injury or in the death of any person. In bodily injury accidents not resulting in death, the total loss or damage caused by the accident must exceed $500.00.

(e) Notwithstanding any other provision of this Section, an insurer may not consider there to be a substantial increase in the hazard insured against unless part of the circumstances which constitute the substantial increase in the hazard insured against occurred after the most recent issuance or renewal of the policy, or unless part of the circumstances which constitute the substantial increase in hazard meet the following criteria:

(1) the circumstance is a traffic violation conviction that,

(A) did not appear on the public record of traffic violation convictions available from the California Department of Motor Vehicles, or did not appear on the public records of other jurisdictions, for which violation points would be counted under Section 2632.13; and,

(B) the insurer obtained the public record not more than 75 days before the most recent renewal or effective date of the policy; and,

(C) the insurer had no notice of the traffic violation conviction when the most recent offer of insurance or renewal was made; or,

(2) the circumstance occurred during the 60 days preceding the most recent renewal or effective date of the policy, and the insurer had no notice thereof.

(f) Notwithstanding any other provision of this Section, if a substantial increase in the hazard insured against exists because of the violation points or circumstances of any person other than the insured, then a substantial increase in the hazard insured against shall not exist if the insured excludes such other person from coverage.

NOTE: Authority cited: Sections 1861.03, 12921 and 12926 of the California Insurance Code. Reference: Section 1861.03 of the California Insurance Code.

HISTORY

1. New section filed 12–2–93; operative 1–3–94 (Register 93, No. 49).
2. Amendment of subsections (a)(2), (a)(8)(B) and (b)(4), new subsection (b)(6), subsection renumbering, and amendment of subsections (c)(1)(A)–(C), (d) and (e)(1)(A) filed 10–5–98; operative 11–4–98 (Register 98, No. 41).
3. Amendment of subsection (b)(3), new subsection (b)(4), subsection renumbering, new subsection (b)(9), repealer of subsection (c)(1)(A), subsection relettering, amendment of newly designated subsection (c)(1)(A), and amendment of subsection (c)(2) filed 10–5–98; operative 11–4–98 (Register 98, No. 41).

Subchapter 4.8. Review of Rates

Article 1. Scope

§ 2641.1. Implementation of Proposition 103.

This subchapter is adopted to implement the provisions of Proposition 103 governing approval of insurance rates.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. Repealer of former subchapters 4.8. and 4.9. filed pursuant to Government Code section 11346.1(g) (Register 92, No. 3). For prior history, see Register 91, No. 8 and 13, respectively.
2. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.

3. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
4. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2641.2. Applicability.

This subchapter applies to all rates charged for insurance on risks or on operations in this state except insurance exempted by Insurance Code section 1851, insurance for which rates are set by the federal government, and, to the extent provided herein, surety, credit, and financial guaranty insurance.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1851, 1861.01, 1861.05, 1861.13, 1861.135, 1861.137 and 12120, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2641.3. Purpose.

The purpose of this subchapter is to establish the process and policies the Commissioner shall employ to determine whether proposed rates are excessive or inadequate.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

Article 2. Definitions

§ 2642.1. Excessive.

"Excessive" rates are rates that are expected to yield the reasonably efficient insurer a profit that exceeds a fair return on the investment used to provide the insurance. In determining whether a rate is excessive, the Commissioner shall consider the competing interests of consumers in lower prices and of investors in prices that yield high returns, and the Commissioner shall consider the fact that insurance is imbued with the public interest and is sometimes legally required.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2642.2. Fair Return.

A fair return is the profit an investor can reasonably expect to earn from an investment in a business other than insurance subject to regulation under this subchapter presenting investment risks comparable to the risks presented by insurance subject to this subchapter.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2642.3. Inadequate.

"Inadequate" rates are rates under which a reasonably efficient insurer is not expected to have the opportunity to earn a fair return on the investment that is used to provide the insurance. In determining whether a rate is inadequate, the Commissioner shall consider the competing interests of consumers in lower prices and of investors in prices that yield high returns, and the Commissioner shall consider that insurance is imbued with the public interest and sometimes legally required.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2642.4. Pure Premium.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2642.5. Rating Period.

"Rating period" means the period that must be accounted for in the application. The rating period shall be one year commencing on the effective date of the rates. Nothing in this section shall be construed to specify the frequency of rate filings.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2642.6. Recorded Period.

"Recorded period" means the historical period from which data are taken to provide the basis for the proposed rate. The recorded period shall be the most recent three years for which reliable data are available, unless

(1) the credibility of that experience is less than the value contained in section 2644.23(i). In that case, additional years shall be added to the recorded period until sufficient years are used to reach the credibility standard set forth in section 2644.23(i). In no case shall the recorded period exceed six years.

(2) the data is fully credible with fewer than three years experience. In that case, only as many years as needed to be fully credible shall be used.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment of subsection (1) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2642.7. Lines of Insurance.

(a) Wherever in this subchapter insurance is required to be classified by line, the classification shall be into one of the following categories:

(1) Fire
(2) Allied Lines
(3) Farmowners multiple peril
(4) Homeowners multiple peril
(5) Commercial multiple peril liability
(6) Commercial multiple peril non–liability
(7) Inland marine
(8) Medical malpractice
(9) Earthquake
(10) Other liability
(11) Products liability
(12) Private passenger automobile liability
(13) Private passenger automobile physical damage
(14) Commercial automobile liability
(15) Commercial automobile physical damage
(16) Aircraft
(17) Fidelity
(18) Surety
(19) Burglary and theft
(20) Boiler and machinery.

(b) For purposes of this subchapter, mechanical breakdown and similar insurance covering loss caused by the failure or malfunction of a component or system of a motor vehicle, as described in California Insurance Code Section 116(c), shall be classified as other liability occurrence.

(c) Any insurer or the Commissioner may disaggregate any of the foregoing lines, except homeowners multiple peril, private passenger automobile liability, and private passenger automobile physical damage, into two subcategories, "commodity" and "specialty." Rates for specialty insurance shall be approved or disapproved using the most sound actuarial method, consistent with California law, in accordance with the Actuarial Standards of Practice, and relevant and accepted actuarial principles, guidelines, and literature.

(d) Specialty insurance shall include:

(1) Any single policy having an annual premium over $75,000;

(2) Any policy having a deductible or self–insured retention of $100,000 or more;

(3) Any excess property, excess liability, or umbrella policy, where none of the underlying policies include private passenger automobile liability, private passenger automobile physical damage, or homeowners coverage, or where the underlying policy is written by an unaffiliated insurer and covers at least the first $500,000 in losses;

(4) All policies for
(A) nuclear risks,
(B) pollution legal liability,
(C) product–tampering, product impairment, or product recall,
(D) kidnap and ransom,
(E) political risks,
(F) directors' and officers' liability,
(G) boiler and machinery insurance,
(H) fidelity insurance,
(I) mortgage guaranty insurance,
(J) employer liability under the United States Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. section 901 et seq.), the Jones Act (46 U.S.C. section 688), the Federal Employer Liability Act (45 U.S.C. section 51 et. seq.), or any similar statute,
(K) excess employer's liability over workers' compensation insurance,
(L) differences in conditions coverage,
(M) surety,
(N) credit, and
(O) aviation.

(e) Commodity insurance shall include all policies in the line that are not defined in this section as specialty.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. New subsection (a)(18), subsection renumbering, amendment of subsections (d)(4)(K)–(L) and new subsections (d)(4)(M)–(O) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2642.8. Most Actuarially Sound.

The "most actuarially sound" choice is the most appropriate choice within the range of permissible actuarially sound choices, considering both the relative likelihood of all choices within the range and the context in which the choice will be employed.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

Article 3. General Provisions

§ 2643.1. Common Methodology for Review.

While companies remain free to formulate their rates under any methodology, the Commissioner's review of those rates must use a single, consistent methodology.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2643.2. Rating Basis.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

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2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2643.3. Total Aggregate Earned Premiums.

(a) The determination whether rates are excessive or inadequate is made on the basis of the aggregate earned premiums the rates are expected to produce. Thus, the proposed and approved rates are required to reflect the actual distribution of premiums, including discounts, dividends, credits, and other rating factors affecting aggregate premiums. Rates that are neither excessive nor inadequate may still be unlawful and disapproved if they are unfairly discriminatory or otherwise violate chapter 9 (commencing with section 1851) of part 2 of division 1 of the Insurance Code.

(b) Rate applications (Form CAR–1 (last revised 1/94)) shall be filed on a line–by–line basis, as set forth in section 2642.7. The application shall be accompanied by the rating manual, rating plan, all policy forms to which changes would have a rate impact, or such other documents as may be necessary to show the distribution of premium within the line. The Commissioner shall require the filing of such other information as he or she deems necessary to review the application.

(c) The earned premium of retrospectively rated and loss–sensitive insurance shall be the manual premium.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2643.4. Line–by–Line Ratemaking.

NOTE: Authority cited: Sections 1861.01, 1861.05, 12921 and 12926 of the Insurance Code; sections 11152 and 11342.2 of the Government Code. Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).

§ 2643.5. Accounting Principles.

Statutory accounting principles ("SAP"), rather than generally accepted accounting principles ("GAAP"), shall be used to measure equity.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2643.6. Interjurisdictional Allocations.

(a) Data shall be submitted with a rate application. Where reliable data exist for California losses, defense and cost containment expenses, ancillary income, commissions, state premium taxes, loss reserves, and unearned premium reserves, those data shall be used. Where data are maintained on a multi–state basis only, or where California data are not reliable, the multi–state data shall be allocated to California as follows:

(1) Defense and cost containment and adjusting and other expenses: By dollars of incurred losses.

(2) Commissions and brokerage: By earned premium.

(3) Taxes, licenses, and fees: By actual statutory tax rate for premium tax; by premium for licenses and fees.

(4) Other Acquisition: By number of written exposures or policies.

(5) General: By number of earned exposures or policies.

For purposes of this subsection, the determination whether data are "reliable" shall be made on the basis of whether the Commissioner finds, under the circumstances, that the data are authentic and believable. In making that finding, the Commissioner shall consider, among other things, whether the data were recorded by persons and under circumstances likely to produce accurate data, whether the data were relied upon by the party in its business, and whether the data are consistent with other data.

(b) Where an insurer submits recorded California data that varies from the California allocation of multi-state data allocated as specified in this section, the Commissioner shall require the insurer to demonstrate the accuracy of the data and to justify any deviation from the insurer's experience in other states. Where the Commissioner finds the demonstration or justification inadequate, he or she shall require the use of allocations rather than the submitted recorded data for California. Where the data are expressed as a percentage of earned premium, and are therefore mathematically related to the other components of premium, and the use of data other than the California allocation of multi-state data is authorized, appropriate adjustments shall be made to any related data and to any applicable regulatory standards.

(c) Where an insurer or the Commissioner elects to disaggregate a line of insurance into commodity and specialty categories pursuant to section 2642.7, allocations between commodity and specialty shall be in the same proportion as specified in subdivision (a) of this section.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8-13-91 as an emergency; operative 8-13-91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12-11-91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2-14-92 as an emergency; operative 2-14-92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6-15-92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3-15-95; operative 3-15-95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of subsections (a), (a)(1) and (c) filed 1-3-2007; operative 4-3-2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2643.7. Data Availability.

Where an insurer can demonstrate that data required by these regulations are not available, the Commissioner shall authorize the use of substitute data. An insurer seeking authority under this section shall include with its request

(a) the reasons why the data are unavailable to it, with appropriate reference to the practices of other, comparably situated insurers;

(b) justification for use of the substitute data proposed, together with a discussion of other feasible alternatives;

(c) a plan for providing the data required by these regulations, taking into account the practical requirements of full compliance and the size and scope of the insurer's affected operations.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8-13-91 as an emergency; operative 8-13-91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12-11-91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2-14-92 as an emergency; operative 2-14-92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6-15-92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3-15-95; operative 3-15-95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2643.8. Factors Calculated by Commissioner.

Where regulations within Article 4 of this title specify that the Commissioner calculate and publish values for use in review of rate applications, the values used shall be the most recently published values, provided that the values were published at least 45 days before the receipt of the rate application by the Department's Rate Filing Bureau in San Francisco. Otherwise, the values used shall be those published immediately prior to publication of the most recent values.

If the Commissioner does not publish the values required by these regulations within the prescribed time period, the Rate Filing Bureau and, if applicable, the Administrative Hearing Bureau shall review the application by performing the calculations in the manner set forth in these regulations. Values used by the Rate Filing Bureau shall be updated by the Administrative Hearing Bureau before the close of the evidentiary hearing if one year or more has passed since the application was received.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 1-3-2007; operative 4-3-2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

Article 4. Determination of Reasonable Rates

§ 2644.1. Excessive or Inadequate Rates.

No rate shall be approved or remain in effect that is above the maximum permitted earned premium, as defined in section 2644.2, or is below the minimum permitted earned premium, as defined in section 2644.3. Where the Commissioner finds that a rate or proposed rate is excessive or inadequate, the rate or proposed rate shall not be used nor remain in effect. If the rate or proposed rate is excessive, the Commissioner shall indicate the highest rate that would not be excessive, which the insurer may adopt by amendment to its application, or the Commissioner shall reject the rate in its entirety. If the rate or proposed rate is inadequate, the Commissioner shall indicate the lowest rate that would not be inadequate, which the insurer may adopt by amendment to its application, or the Commissioner shall reject the rate in its entirety.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8-13-91 as an emergency; operative 8-13-91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12-11-91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2-14-92 as an emergency; operative 2-14-92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6-15-92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3-15-95; operative 3-15-95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2644.2. Maximum Permitted Earned Premium.

The maximum permitted earned premium is calculated as follows:

(a) the quotient of

(1) the sum of

(A)(i) projected losses, as defined in section 2644.4,

(ii) plus projected defense and cost containment expenses, as defined in section 2644.8,

(B) multiplied by 1 minus the fixed investment income factor as defined in section 2644.19(a),

(2) minus projected ancillary income, as defined in section 2644.13,

(b) divided by the maximum denominator, as defined in section 2644.2(c).

Stated as a formula:

$$\text{Max Permitted EP} = \frac{(\text{losses} + \text{DCCE}) \times (1 - \text{fixed invest inc factor}) - \text{ancil income}}{\text{max denom}}$$

(c) The maximum denominator means:

(1) 1.0,

(2) minus the efficiency standard, as defined in section 2644.12,

(3) minus the maximum profit factor, as defined in section 2644.15,

(4) plus the variable investment income factor, as defined in section 2644.19(b).

Stated as a formula:

Max denom =1 – eff std – profit factor + var invest inc factor

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.3. Minimum Permitted Earned Premium.

The minimum permitted earned premium is calculated as follows:

(a) the quotient of

(1) the sum of

(A)(i) projected losses, as defined in section 2644.4,

(ii) plus projected defense and cost containment expenses, as defined in section 2644.8,

(B) multiplied by 1 minus the fixed investment income factor as defined in section 2644.19(a),

(2) minus projected ancillary income, as defined in section 2644.13,

(b) divided by the minimum denominator, as defined in section 2644.3(c).

Stated as formula:

$$\text{Min Permitted EP} = \frac{(\text{losses} + \text{DCCE}) \times (1 - \text{fixed invest inc factor}) - \text{ancil income}}{\text{min denom}}$$

(c) The minimum denominator means:

(1) 1.0,

(2) minus the efficiency standard, as defined in section 2644.12,

(3) minus the minimum profit factor, as defined in section 2644.15,

(4) plus the variable investment income factor, as defined in section 2644.19(b).

Stated as a formula:

Min denom =1– eff std – profit factor + var invest inc factor

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.4. Projected Losses.

(a) "Projected losses" means the insurer's historic losses per exposure, adjusted by catastrophe adjustment, as prescribed in section 2644.5, by loss development, as prescribed in section 2644.6, and by loss trend, as prescribed in section 2644.7.

(b) Projected losses shall be calculated by applying the loss trend factor separately to data from each accident–year in the recorded period. However, for claims–made policies projected losses shall be calculated on a report–year basis.

(c) For policies providing multi–year coverage, such as mechanical breakdown, projected losses may be calculated on a policy–year basis.

(d) For professional liability and errors and omissions coverage, the insurer shall, in lieu of the computation of projected losses specified in sections 2644.5 through 2644.7, tender an alternative computation of projected losses, which the Commissioner shall approve if he or she finds the projection to have been made in the most sound actuarial manner. Nothing in this section precludes the Commissioner from requiring the additional filing of projected losses computed in the manner specified in sections 2644.5 through 2644.7.

(e) For the earthquake line of business and for the fire following earthquake exposure in other lines, projected losses and defense and cost containment expenses may be based on complex catastrophe models using geological and structural engineering science and insurance claim expertise. The use of such models shall conform to the standards of practice as set forth by the Actuarial Standards Board and the applicant shall have the burden of proving, by a preponderance of the evidence, that the model is based upon the best available scientific information for assessing earthquake frequency, severity, damage and loss, and that the projected losses derived from the model meet all applicable statutory standards.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.5. Catastrophe Adjustment.

In those insurance lines and coverages where catastrophes occur, the catastrophic losses of any one accident year in the recorded period are replaced by a loading based on a multi–year, long–term average of catastrophe claims. The number of years over which the average shall be calculated shall be at least 20 years for homeowners multiple peril fire, and at least 10 years for private passenger auto physical damage. Where the insurer does not have enough years of data, the insurer's data shall be supplemented by appropriate data. The catastrophe adjustment shall reflect any changes between the insurer's historical and prospective exposure to catastrophe due to a change in the mix of business. There shall be no catastrophe adjustment for private passenger auto liability.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).

3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.6. Loss Development.

"Loss development" is the process by which reported losses are adjusted for anticipated payout patterns. Loss development shall be presented as a loss–development triangle, based on the dollar–weighted average of the ratios of losses for the three most recent accident–years, policy–years or report–years available for a reporting interval. Filings shall contain both paid losses and case–specific reserves, stated separately. Loss development shall employ either paid losses or the sum of paid losses and case–specific reserves. The insurer shall submit both the factors and ultimate losses or claims for the paid and incurred loss and the reported and the paid claims development calculations, and shall demonstrate that its selection is the most actuarially sound. Loss development data shall exclude catastrophes. Where the loss development factors within a given line significantly vary by subline, by size of loss, or by coverage, separate loss development factors shall be calculated in accordance with that evidence.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.7. Loss and Premium Trend.

(a) "Loss trend" and "premium trend" is the process by which forces not reflected in historical loss and premium data are expected to affect losses and premiums in the rating period.

(b) Trend factors shall be based on the exponential curve of best fit. Companies shall file the most recent 8, 12, 16, 20, and 24 quarters of rolling calendar year data excluding catastrophes. The premium and loss trend factors shall be developed using the insurer's most actuarially sound company–specific rolling calendar year data excluding catastrophes, for the most recent 8, 12, 16, 20, or 24 quarters. The insurer shall file its rate change application using the single data period that it determines to be the most actuarially sound. The Commissioner may require the use of an alternative data period if the Commissioner determines that use of the alternative is the most actuarially sound. Frequency trend shall be calculated as reported or closed claims divided by exposures. Severity trend shall be calculated on paid losses divided by closed claims or total paid losses, including partial payments in previous calendar years, on closed claims divided by closed claims. The insurer shall submit the frequency and severity calculations on all bases, and shall demonstrate that its selection is the most actuarially sound. Premium trend factors shall be developed using company–specific premium per exposure data.

(c) Where the trend factor within a given line significantly varies by subline, by policy limits, by region of the state, or by coverage, separate trend factors shall be calculated in accordance with that evidence.

(d) For homeowners multiple peril and private passenger automobile liability and physical damage, the standard for full credibility for loss trend shall be 6000 total claims over the same number of quarters as used in subsection (b) for each form for homeowners and for each coverage for private passenger automobile. Partial credibility shall be the square root of the ratio of the actual number of claims divided by the full credibility standard. For private passenger automobile other than motorcycle, the complement of credibility for loss trend shall be calculated using the latest available California Fast Track paid loss, closed claim count and earned exposure data, The complement shall be based on the exponential curve of best fit to the most recent rolling calendar year data for the same number of quarters as used in subsection (b). For uninsured and underinsured motorist bodily injury and medical payments coverages, the complement shall use the California Fast Track bodily injury data. For uninsured and underinsured motorist property damage coverages, the complement shall use the California Fast Track property damage data. The Commissioner may modify the result of the calculation from California Fast Track data to take into account factors not reflected in the historical data, pursuant to section 2646.3.

(e) For lines of business other than homeowners multiple peril and private passenger automobile liability and physical damage, the standard for full credibility for loss trend shall be determined using the most actuarially sound method. For lines of business other than private passenger automobile liability and physical damage, the standard for the complement of credibility for loss trend shall be determined using the most actuarially sound method.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of section heading and section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.8. Projected Defense and Cost Containment Expenses.

(a) "Projected defense and cost containment expenses" means the company's historic costs per exposure associated with the defense and cost containment of claims, adjusted for catastrophes, developed and trended in the manner described in sections 2644.5, 2644.6 and 2644.7.

(b) Defense and cost containment expenses may be added to losses for loss development and trend or may be developed using ratios of defense and cost containment expenses to losses. The insurer shall demonstrate that its selection is the most actuarially sound.

(c) For professional liability and errors and omissions coverage, the insurer shall tender an alternative computation of projected defense and cost containment expenses, which the Commissioner shall approve if he or she finds the projection to have been made in the most sound actuarial manner. Nothing in this section precludes the Commissioner from requiring the additional filing of projected defense and cost containment expenses computed in the manner specified in sections (a) and (b).

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and

1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of section heading and section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment of subsection (b) and repealer and new subsection (c) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.9. Projected Fixed Expenses.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.10. Excluded Expenses.

The following expense items shall not be allowed for ratemaking purposes:

(a) Political contributions and lobbying.

(b) Executive compensation that exceeds the reasonable amount for such compensation.

For purposes of this computation, the following shall apply:

(1) "Executive" means the insurer's five highest–paid policymaking positions in each insurance group.

(2) "Compensation" means the total cash paid, including salary and bonus.

(3) "Maximum permissible executive compensation" means:

(A) For the highest paid executive in the group:

max comp = $1077(10^{1.4600 + 0.4060 \log X})$

(B) For the second–highest paid executive in the group:

max comp = $1077(10^{1.4140 + 0.3490 \log X})$

(C) For the third–highest paid executive in the group:

max comp = $1077(10^{1.2310 + 0.3820 \log X})$

(D) For the fourth–highest paid executive in the group:

max comp= $1077(10^{1.2470 + 0.3580 \log X})$

(E) For the fifth–highest paid executive in the group:

max comp = $1077(10^{1.2460 + 0.3420 \log X})$

where X is the greater of (i) the insurer's total countrywide direct earned premium for the most recent completed calendar year for lines of business subject to Proposition 103 divided by 1,000,000 or (ii) 70.

(c) Bad faith judgments and associated defense and cost containment expenses.

(d) All costs attendant to the unsuccessful defense of discrimination claims.

(e) Fines and penalties.

(f) Institutional advertising expenses. "Institutional advertising" means advertising not aimed at obtaining business for a specific insurer and not providing consumers with information pertinent to the decision whether to buy the insurer's product.

(g) All payments to affiliates, to the extent that such payments exceed the fair market rate or value of the goods or services in the open market.

Except as allocated pursuant to section 2643.6, calculation of the amounts expended on the foregoing expense items shall be based on the insurer's national expenditures, allocated among states in proportion to earned premium.

The disallowance shall be effected by reducing the efficiency standard by the ratio of the insurer's national excluded expenses to its national direct earned premium.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of subsections (b), (c) and (g) and new subsections (b)(1)–(b)(3)(E) filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.11. Expense Trend.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.12. Efficiency Standard.

(a) The Commissioner shall calculate the efficiency standard annually, within 45 days of the publication of the necessary source data, which shall be expressed as a maximum allowable ratio of historic underwriting expenses, including adjusting and other expenses, to historic earned premiums, which represents the fixed and variable cost for a reasonably efficient insurer to provide insurance and to render good service to its customers.

(b) The efficiency standard shall be set separately for each insurance line, and separately for insurers distributing through independent agents and brokers, through exclusive agents, and through employees of the insurer selling insurance on a direct basis. For an insurer using more than one distribution system, the efficiency standard shall consist of an average weighted by earned premium for each distribution system. In setting the efficiency standard, the Commissioner shall determine whether, in the long–term, efficiency will be enhanced and premiums lowered by adopting a separate standard for insurers writing large and small amounts of insurance in the line. If the Commissioner determines that such separate standards would have such long–term effects, he or she shall set the standard separately according to the amount of insurance being written in the line, pursuant to section 2646.3. In lines where the number of insurers employing a given distribution system is, in the judgment of the Commissioner, inadequate for the calculation of a mean that provides a useful

efficiency standard, the Commissioner shall adopt a single efficiency standard for that line, pursuant to section 2646.3, which shall apply to all insurers writing in that line regardless of distribution system. For lines of business that combine personal and commercial exposures, the commissioner may set separate efficiency standards, pursuant to section 2646.3.

(c) The efficiency standard shall be calculated as the arithmetic average of the latest three years for which data are available.

(d) For farmowners, the efficiency standard for captive insurers shall be the average for all distribution systems combined.

(e) For earthquake, the efficiency standard shall exclude adjusting and other expenses. Adjusting and other expenses shall be added to defense and cost containment expenses.

(f) For burglary and theft, all distribution systems shall be combined, and a five-year average shall be used.

(g) In each category, the efficiency standard shall be set at the weighted mean (weighted by earned premium in California) expense ratio of insurers in that category. In calculating the average, the Commissioner may exclude insurers for which reliable data are not readily available.

(h) All data shall be taken from the National Association of Insurance Commissioners database of the statutory annual statement state page and of the Insurance Expense Exhibit, Part III.

(i) A company's data shall be included in the calculation only if

(1) The company is licensed in California;

(2) The company's California direct earned premium is greater than zero;

(3) The company's countrywide direct earned premium is greater than zero;

(4) The company's countrywide direct losses incurred is greater than zero; and

(5) The company's ratio of underwriting expenses, including adjusting and other expenses, to earned premium is greater than zero and less than 65%.

(j) If a company's commission expense is less than zero, the negative amount shall be set to zero.

(k) If a company's California allocated other acquisition expense is less than zero, the negative amount shall be set to zero.

(*l*) If a company's California allocated general expense is less than zero, the negative amount shall be set to zero.

(m) If a company's tax, licenses and fees expense is less than zero, the negative amount shall be set to zero.

(n) Countrywide expenses for general and other acquisition expenses shall be allocated to California on the basis of direct earned premium. Countrywide expenses for adjusting and other expenses shall be allocated to California on the basis of direct incurred losses.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer of subsections (a)–(a)(3)(D), subsection relettering, amendment of newly designated subsections (a), (b) and (d) and new subsections (c) and (e)–(k) filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. New subsections (d)–(f), subsection relettering and amendment of newly designated subsection (n) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.13. Projected Ancillary Income.

"Projected ancillary income" means projected net income to the insurer, or an affiliate of the insurer, not derived from insurance premiums subject to this subchapter but derived from operations directly related to insurance subject to this subchapter. Projected ancillary income shall be expressed on a per-exposure basis. Premium financing revenues and membership dues shall be included within projected ancillary income. "Affiliate" means a company having common management, ownership, or control with the insurer.

NOTE: Authority cited: Section 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Section 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Editorial correction amending section (Register 2005, No. 18).

§ 2644.14. Variable Expense Factor.

The "variable expense factor" means the sum of the commission rate and the state premium tax rate.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2644.15. Profit Factors.

(a) The "maximum profit factor" means

(1) The maximum permitted after-tax rate of return, as defined in section 2644.16,

(2) divided by the product of

(A) the leverage factor, as defined in section 2644.17,

(B) multiplied by the underwriting federal income tax factor, as defined in section 2644.18.

(b) The "minimum profit factor" means

(1) the minimum permitted after-tax rate of return, as defined in section 2644.16,

(2) divided by the product of

(A) the leverage factor, as defined in section 2644.17,

(B) multiplied by the underwriting federal income tax factor, as defined in section 2644.18.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.

4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of subsections (a)(2)(B) and (b)(2)(B) filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.16. Rate of Return.

(a) The maximum permitted after–tax rate of return means the risk–free rate, as defined in section 2644.20(d), plus 6%.

(b) The minimum permitted after–tax rate of return shall be –6%, which the Commissioner finds is high enough to prevent any undue risk of insolvency and to prevent injury to competition through predatory pricing.

(c) The Commissioner may increase or decrease the maximum permitted after–tax rate of return by not more than 2% if he finds financial market conditions to be such that the difference between the risk–free rate and the cost of capital is significantly different from its historical average.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer and new section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. New subsection (c) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.17. Leverage Factor and Surplus.

(a) "Leverage factor" means the ratio of earned premiums to the average of year–beginning and year–end surplus.

(b) The Commissioner shall calculate industry–wide leverage factors for each insurance line annually, within 45 days of the publication of the necessary source data. The factors shall be calculated using the consolidated underwriting and investment exhibit as published in Best's Aggregates and Averages. The allocation of the commercial multiple peril data to liability and non–liability and the allocation of the automobile physical damage data to private passenger and commercial shall be done using data from the Exhibit of Premiums and losses (Statutory Page 14 Data) as published in Best's Aggregates and Averages. For medical malpractice, other liability and product liability, there shall be separate leverage factors for claims–made and occurrence. Total national industry surplus shall be allocated to lines of business in proportion to the sum of the national industry–wide earned premium, unearned premium, loss and loss adjustment expense reserves. The leverage factor for each line of business shall be the national premium divided by the allocated surplus.

Notwithstanding the result of the calculation, the leverage factor for earthquake shall be 1.0. For other lines of business subject to catastrophes, mass torts and other unusual events, the Commissioner shall modify the leverage factors where he finds that they do not provide a reliable estimate of future risk, pursuant to section 2646.3.

(c) The Commissioner finds that investors' perceived investment risk may vary from line to line. Thus, while the rate of return does not vary by line, insurance perceived to have a greater risk will yield higher returns per premium dollar.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment of subsection (b) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.18. Federal Income Tax Factors.

(a) "Underwriting federal income tax factor" means 1.0 minus the prospective federal income tax rate on underwriting. The Commissioner finds that the prospective federal income tax rate on underwriting is 35%.

(b) "Investment federal income tax factor" means 1.0 minus the prospective federal income tax rate on investment income. The prospective federal income tax rate on investment income shall be calculated using the weighted yield, adjusted for investment expenses, computed in section 2644.20 and shall take into account any tax preferences and exemptions for the income from each asset class and from each category of bond issuer. The Commissioner finds that the prospective federal income tax rate on the investment income from taxable bonds, mortgage loans, real estate, cash and short–term investments and on investment expenses is 35%, on capital gains is 34.1%, on tax–exempt bond interest is 5.25% and on stock dividends is 14.175%. For investment income on other invested assets, the prospective federal income tax rate shall be the weighted average of the tax rates on the above categories.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of section heading and repealer and new section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.19. Investment Income Factors.

(a) "Fixed investment income factor" means the projected yield, as defined in section 2644.20,

(1) multiplied by the ratio of the investment federal income tax factor and the underwriting federal income tax factor, as defined in section 2644.18,

(2) multiplied by the loss reserves ratio, as defined in section 2644.21.

Stated as a formula:

$$\textit{Fixed invest inc factor} = \textit{yield} \times \frac{\textit{FIT inv inc}}{\textit{FIT und}} \times \textit{loss reserves ratio}$$

(b) "Variable investment income factor" means the projected yield, as defined in section 2644.20,

(1) multiplied by the ratio of the investment federal income tax factor and the underwriting federal income tax factor, as defined in section 2644.18,

(2) multiplied by the sum of

(A) the unearned premium reserves ratio, as defined in section 2644.21,

(B) plus the surplus ratio, as defined in section 2644.22.

Stated as a formula:

$$Var\ invest\ inc\ factor = yield\ x\ \frac{FIT\ inv\ inc}{FIT\ und}\ x\ (uep\ reserves\ ratio + surplus\ ratio)$$

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of section heading and repealer and new section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.20. Projected Yield.

(a) "Projected yield" means the weighted average yield computed using the insurer's actual portfolio and yields currently available on securities in US capital markets. The weights shall be determined using the insurer's most recent consolidated statutory annual statement, and shall be computed by dividing the insurer's assets in each separate asset class shown on page 2, lines 1 through 9 of the insurer's consolidated statutory annual statement, by the total of lines 1 through 9. The yields for each asset class shall be based on an average of the most recent available 3 complete months, as of the date of filing.

(b) The bond asset class shall be subdivided into the issuer categories of US government bonds, other taxable bonds and tax exempt bonds and into the maturity categories of short, intermediate and long–term shown. For the purposes of this section, "US government" means the sum of rows 1.7, U.S. governments, and 2.7, all other governments, of schedule D, part 1A, section 1 of the insurer's consolidated statutory annual statement, "other taxable" means the sum of rows 6.7, public utilities, 7.7, industrial and miscellaneous, 8.7, credit tenant loans, 9.7, parent subsidiaries and affiliates and half of row 5.7, special revenue and special assessments and "tax–exempt" means the sum of rows 3.7, states, territories and possessions, 4.7, political subdivision of states, territories and possessions, and half of row 5.7. For the purposes of this section, "short–term" means one year or less, "intermediate–term" means more than one year through 10 years, and "long–term" means more than 10 years.

(c) "Yields currently available on securities in US capital markets" means,

(1) US government bonds

(A) Short: yield on the nominal 3–month constant maturity US Treasury bill as provided in the Federal Reserve H.15 statistical release

(B) Intermediate: yield on the nominal 10–year constant maturity US Treasury bond as provided in the Federal Reserve H.15 statistical release

(C) Long: yield on the nominal 20–year constant maturity US Treasury bond as provided in the Federal Reserve H.15 statistical release

(2) Other taxable bonds

(A) Short: yield on 3–month financial commercial paper as provided in the Federal Reserve H.15 statistical release

(B) Intermediate: average yield on 10–year corporate A and AA rated bonds as provided by Valu/Bond on Yahoo.com

(C) Long: average yield on 20–year corporate A and AA rated bonds as provided by Valu/Bond on Yahoo.com

(3) Tax exempt bonds

(A) Short: yield on short–term other taxable bonds times 1 minus the federal income tax rate of 35%

(B) Intermediate: average yield on 10–year municipal A and AA rated bonds as provided by Valu/Bond on Yahoo.com

(C) Long: average yield on 20–year municipal A and AA rated bonds as provided by Valu/Bond on Yahoo.com

(4) Common stock

(A) Dividends: ten–year average income return as provided in the Ibbotson yearbook

(B) Capital gains: the risk–free rate, below, plus 8%, which the Commissioner finds represents the risk–premium for common stock investments generally, minus dividends, above

(5) Preferred stock dividends: average yield on Moody's A–rated public utility preferred stocks as provided by Mergent Bond Record

(6) Mortgage loans: yield on long–term other taxable bonds, above

(7) Real estate: the risk–free rate, below, plus 2%, which the Commissioner finds represents the risk–premium for real estate investments

(8) Cash and short term: yield on short–term US Treasury bills, above

(9) Other: yield on common stock, above

(d) The "risk–free rate" means the average of the short, intermediate and long–term US government bonds, above, except that the short–term shall be one month instead of three and the intermediate term shall be five years instead of ten.

(e) The projected yield shall be reduced by the ratio of incurred investment expenses, page 11, line 25, column 3, of the insurer's consolidated statutory annual statement, divided by the total of cash and invested assets, page 2, line 10.

(f) The projected yield shall be multiplied by the ratio of cash and invested assets, page 2, line 10 of the insurer's consolidated statutory annual statement, divided by the sum of reserves, page 3, lines 1, 3 and 9, and surplus, page 3, line 35.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer and new section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment of subsection (c)(5) filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.21. Reserves Ratio.

(a) "Unearned premium reserves ratio" means

(1) the average of the last two years ending unearned premium reserves

(2) divided by the earned premium for the most recent year for which data are available.

(b) "Loss reserves ratio" means

(1) the average of the last two years ending

(A) loss reserves plus

(B) loss adjustment expense reserves

(2) divided by the incurred loss and defense and cost containment expense for the most recent year for which data are available.

(c) For burglary and theft, the loss reserve ratio shall be the dollar–weighted average of the loss reserve ratios for fire, allied lines and inland marine.

There shall be one industry–wide unearned premium reserves ratio and one loss reserves ratio for each line of business. The industry–wide

numbers shall be the sum of all such numbers taken from the California state page of the statutory annual statement for all insurers doing business in California. Countrywide adjusting and other expense reserves from Best's Aggregates & Averages shall be allocated to California by loss and defense and cost containment reserves. For medical malpractice, other liability and products liability, California premium and reserves shall be allocated between occurrence and claims-made using countrywide numbers from Best's Aggregates & Averages. The Commissioner shall perform the calculation within 45 days of the publication of the necessary source data. Notwithstanding the result of the calculation, the loss reserves ratio for earthquake shall be 1.0. For other lines of business subject to catastrophes, mass torts and other unusual events, the Commissioner shall modify the industry-wide numbers where he finds that they do not provide a reliable estimate of future expectations of the reserve ratios, pursuant to section 2646.3.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8-13-91 as an emergency; operative 8-13-91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12-11-91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2-14-92 as an emergency; operative 2-14-92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6-15-92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3-15-95; operative 3-15-95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer and new section filed 1-3-2007; operative 4-3-2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. New subsection (c) and redesignation of former second paragraph of subsection (b)(2) as second paragraph of subsection (c) filed 5-16-2008; operative 5-16-2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.22. Surplus Ratio.

"Surplus ratio" means the reciprocal of the leverage factor.

Stated as a formula:

$$\textit{surplus ratio} = \frac{1}{\textit{leverage factor}}$$

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8-13-91 as an emergency; operative 8-13-91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12-11-91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2-14-92 as an emergency; operative 2-14-92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6-15-92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3-15-95; operative 3-15-95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2644.23. Credibility Adjustment.

(a) To the extent that the maximum and minimum permitted earned premiums are based upon data that lack credibility, a credibility adjustment shall be made.

(b) For each form for homeowners multiple peril and for each coverage for private passenger auto liability and physical damage the standard for full credibility shall be 3000 claims. Partial credibility shall be the square root of the ratio of the actual number of incurred claims in the experience period divided by the full credibility standard. For lines of business other than homeowners multiple peril and private passenger automobile liability and physical damage, the standard for full and partial credibility shall be determined using the most actuarially sound method.

(c) When the loss and defense and cost containment expense data is less than fully credible, in the maximum and minimum premium formulas in sections 2644.2 and 2644.3, the following shall be substituted:

(1) The sum of

(A) the credibility weight, as defined in section 2644.23(b),

(B) multiplied by the sum of

(i) projected loss, as defined in section 2644.4,

(ii) plus projected defense and cost containment expense, as defined in section 2644.8,

(2) plus

(A) the difference of

(i) 1.0

(ii) minus the credibility weight, as defined in section 2644.23(b),

(B) multiplied by the complementary loss and defense cost containment expense, as defined in section 2644.23(d).

Stated as a formula:

Credibility weight x (loss + DCCE) + (1- credibility weight) x comp loss DCCE

(d) The complementary loss and defense and cost containment expense means

(1) the quotient of

(A) the sum of

(i) the trended current rate level premium, as defined in section 2644.24,

(ii) multiplied by 1.0 plus the complement trend, as defined in section 2644.23(g),

(iii) multiplied by the maximum denominator, as defined in section 2644.2(c).

(B) plus

(i) the ancillary income, as defined in section 2644.13

(2) divided by 1 minus the fixed investment income factor, as defined in section 2644.19.

Stated as a formula:

Comp loss DCCE = (TCRLP x (1 + comp trend) x max denom + ancil income) /(1 - fixed invest inc factor)

(e) Where the cost of reinsurance is allowed, as provided in section 2644.25, the credibility adjustment in subsection (c) shall be made to loss plus defense and cost containment expense minus reinsurance recoverable, as defined in section 2644.26.

(f) Where the cost of reinsurance is allowed, as provided in section 2644.25, the complementary loss and defense and cost containment expense means

(1) The quotient of

(A) The sum of

(i) the trended current rate level premium, as defined in section 2644.24,

(ii) multiplied by 1.0 plus the complement trend, as defined in section 2644.23(g),

(iii) Multiplied by the maximum denominator, as defined in section 2644.2(c).

(B) plus the ancillary income, as defined in section 2644.13,

(C) Minus the product of

(I) the reinsurance premium, as used in section 2644.25, divided by 1 minus the variable expense factor, as defined in section 2644.14,

(Ii) multiplied by the maximum denominator, as defined in section 2644.2(c),

(2) Divided by 1 minus the fixed investment income factor, as defined in section 2644.19.

Stated as a formula:

Comp loss DCCE = (TCRLP x (1 + comp trend) x max demon + ancil income - reins perm / (1 - vary exp factor) x max demon)/(1 - fixed invest Inc factor)

(g) The complement trend means the annual net trend plus one, raised to the power of the number of years from the effective date of the current rate to the proposed effective date of the proposed rates, minus one.

Stated as a formula:

Comp trend = ((annual net trend+1)^number of years) –1

If the number of years from the effective date of the current rate to the proposed effective date of the proposed rates exceeds four, the complement trend shall be the annual net trend plus one, raised to the fourth power, minus one.

(h) The annual net trend is the ratio of the loss trend, as defined in section 2644.7, annualized, plus one, divided by the premium trend, as defined in section 2644.7, annualized, plus one, minus one.

Stated as a formula:

Annual net trend = ((annual loss trend +1)/(annual premium trend +1))–1

(i) If the credibility weight is less than 25% the applicant or the Commissioner may use an alternative complementary loss and defense and cost containment expense, provided that the alternative is the most actuarially sound method.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of subsection (a), repealer and new subsections (b) and (c) and new subsections (c)(1)–(g) filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
6. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.24. Trended Current Rate Level Earned Premium.

"Trended current rate level earned premium" means the earned premium per exposure for the recorded period adjusted to the current rate level based on subsequent rate changes and further adjusted for premium trend. The trend adjustment shall be calculated by applying the premium trend factor separately to data from each year in the recorded period.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.25. Reinsurance.

(a) For all lines and sublines except for those listed in the next subparagraph, ratemaking shall be on a direct basis, with no consideration for the cost or benefits of reinsurance.

(b) For earthquake and for medical malpractice facultative reinsurance with attachment points above one million dollars, the maximum permitted earned premium is calculated as follows:

The sum of

(1) the quotient of

(A) the difference of

(i) the product of

a. the projected losses, as defined in section 2644.4, plus the projected defense and cost containment expense, as defined in section 2644.8, minus the projected reinsurance recoverables, as defined in section 2644.26,

b. multiplied by 1 minus the fixed investment income factor, as defined in section 2644.19(a),

(ii) minus the projected ancillary income, as defined in section 2644.13,

(B) divided by the sum of

(i) 1.0,

(ii) minus the efficiency standard, as defined in section 2644.12,

(iii) minus the maximum profit factor, as defined in section 2644.15,

(iv) plus the variable investment income factor, as defined in section 2644.19(b).

(2) plus the quotient of

(A) the reinsurance premium, net of ceding and contingent commissions,

(B) divided by the difference of

(i) 1.0,

(ii) minus the variable expense factor, as defined in section 2644.14.

Stated as a formula:

$$\text{Max permitted EP} = \frac{(\text{losses} + \text{DCCE} - \text{recoverables}) \times (1 - \text{fixed invest income factor}) - \text{ancil inc.}}{1 - \text{eff std} - \text{profit factor} + \text{var invest inc factor}} + \frac{\text{reins premium}}{1\text{-var exp factor}}$$

(c) For the calculation of fixed investment income factor, the numerator and denominator of the loss reserves ratio shall be adjusted for projected reinsurance recoverables, and for the variable investment income factor, the numerator and denominator of the unearned premium reserve ratio shall be adjusted to reflect the cash flows of the unearned reinsurance premium.

(d) Reinsurance costs shall be allowed for ratemaking purposes as set forth in this section only if: (1) the reinsurance agreement was entered into in good faith in an arms–length transaction and at fair market value for the coverage provided, and (2) the reinsurance meets the statement credit requirements of Sections 2303 through 2303.25.

(e) There will be no allowance for reinsurance between affiliated entities as set forth in Schedule Y of the Annual Statement.

(f) Copies of the reinsurance agreements shall be submitted with the filing.

(g) For the purposes of this section and section 2644.26, reinsurance shall include other risk financing mechanisms, such as catastrophe bonds.

(h) For the earthquake line, if at least 30% of the requested rate results from the cost of reinsurance, and a consumer or his or her representative requests a hearing within 45 days of public notice, the Commissioner shall hold a hearing on the issue of the reasonableness of the reinsurance costs, as defined in section (d), and whether some or all of those costs shall be reflected in the proposed rate change. An insurer's rate application shall indicate whether at least 30% of the requested rate results from the cost of reinsurance.

(i) For the medical malpractice line, if at least 30% of the requested rate is attributable to the cost of facultative reinsurance with attachment points above one million dollars, and a consumer or his or her representative requests a hearing within 45 days of public notice, the Commissioner shall hold a hearing on the issue of the reasonableness of the reinsurance costs, as defined in section (d), and whether some or all of those costs shall be reflected in the proposed rate change. An insurer's rate application shall indicate whether at least 30% of the requested rate results from the cost of reinsurance.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
2. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.26. Reinsurance Recoverables.

"Reinsurance recoverables" means all amounts recoverable from reinsurers for paid and unpaid losses and loss adjustment expenses per exposure, including estimated amounts receivable for unsettled claims and

claims incurred but not reported as provided under reinsurance agreements.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2644.27. Variance Request.

(a) A request that the maximum permitted earned premium or minimum permitted earned premium should be adjusted is referred to as a "variance request."

(b) Requests for variances shall be filed with the Rate Filing Bureau on pages 11a and 11b of the Prior Approval Rate Application. All such variance requests shall specifically:

(i) identify each and every variance request;

(ii) identify the extent or amount of the variance requested and the applicable component of the ratemaking formula;

(iii) set forth the expected result or impact on the maximum and minimum permitted earned premium that the granting of the variance will have as compared to the expected result if the variance is denied; and

(iv) identify the facts and their source justifying the variance request and provide the documentation supporting the amount of the change to the component of the ratemaking formula.

(c) Requests for variances shall be filed at the same time as the prior approval application to which it applies or after the filing of the rate application and before any final determination regarding that application. Public notice of all variance requests shall be provided as set forth in California Insurance Code Sections 1861.05(c) and 1861.06.

(d) A variance request shall be deemed approved sixty days after public notice unless:

(i) a consumer or his or her representative requests a hearing within forty–five days of public notice and the Commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or

(ii) the Commissioner on his or her own motion determines to hold a hearing.

(e) Variance requests shall be determined in conjunction with the related prior approval application or rate hearing thereon.

(f) The following are the valid bases for requesting a variance:

(1) That the insurer should be allowed relief from the efficiency standard for bona fide loss–prevention and loss–reduction activities as set forth below.

(A) The insurer meeting the qualifications set forth below may obtain an increase in the applicable efficiency standard by the amount of its "Allocated Costs" for its Special Investigations Unit ("SIU") expense for the most recent year. The term SIU as used in this section has the same meaning as that term has in Section 2698.30(o). The term "Allocated Costs" means those costs set forth in subsection (iii) and attributable to investigations of claims made on the line of insurance subject to Insurance Code section 1861.05(b) for which the variance is sought.

(i) An insurer may recover its "Allocated Costs" for its SIU expenses only in its approved rate filing for the line of insurance affected by the SIU investigation costs.

(ii) Affiliated insurers who utilize the same SIU unit may recover the portion of their "Allocated Costs" for their SIU expenses attributable to investigations of claims made on the line of insurance in the rate application only in one approved rate application for the line affected by the Allocated SIU costs. The term "Affiliated Insurers" has the same meaning as that term has in Insurance Code Section 1215.

(iii) The only recoverable SIU expenses are those expended for investigators whose sole duties are investigation of insurance fraud, software dedicated solely to analysis of data for indications of insurance fraud, training of employees whose sole duty is the investigation of fraud and equipment to be used solely by the insurer's SIU. The recoverable expenses do not include the costs of employing or other costs for adjustors or underwriters.

(iv) The only recoverable SIU expenses are for SIU's dedicated to investigation of insurance fraud within the State of California or for the portion of an SIU's operations within California. The burden of demonstrating the amount of SIU expenses, and that those expenses are for the investigation of insurance fraud within the State of California is the insurers.

(v) An insurer may recover the "Allocated Costs" of retaining an independent contractor to perform SIU services as described in sub–paragraph (iii). The variance shall be calculated by multiplying the fees paid for the independent agency with whom the insurer contracts by the percentage of referrals of claims made on the line of insurance for which the rate application and variance application are made and that the contracted agency investigates in California on behalf of the insurer seeking the variance.

(vi) No expense that is included within the Defense and Cost Containment Expense portion of an insurer's rate application can be included in whole or in part as the basis for a variance based on SIU expenses. The terms "Defense and Cost Containment Expense" or "DCCE" when used with regard to any variance have the same meaning as those terms have in section 2644.23(c).

(vii) An insurer that asserts that payments to: (1) an independent contractor; or (2) an SIU owned by an Affiliated Insurer; or (3) an SIU independent of an insurer, but which is owned directly or indirectly, in whole or part by the insurer applying for a variance or by an Affiliated Insurer, shall in its variance request, provide the Department of Insurance with documentation showing the costs of investigation for the purported "Allocated Costs" claimed in the variance request. The payments constituting the basis for the variance must be *bona fide* payments for investigation of individual cases of suspected insurance fraud. It shall be the burden of the insurer to demonstrate that the costs are *bona fide* costs for investigation of insurance fraud in the State of California.

(B) An insurer meeting the qualifications set forth below will be allowed to recover its expenses for the most recent year for dedicated loss prevention programs such as brush clearance, driver education, risk management, hazard mitigation or accident prevention. Loss prevention expenses do not include SIU expenses under subsection (A).

(i) An insurer may recover its "Allocated Costs" for its loss prevention expenses only in its approved rate for the line of insurance affected by the loss prevention expenses.

(ii) The insurer must provide documentation detailing the loss prevention program, what additional costs are being incurred and what losses are being prevented.

(iii) Recoverable loss prevention expenses are those expended for employees whose duties are loss prevention, software dedicated to loss prevention, and equipment to be used for loss prevention. Recoverable loss prevention expenses do not include the routine and customary costs of marketing or employing underwriters or adjusters.

(iv) The only loss prevention expenses recoverable are for loss prevention programs dedicated to loss prevention in the State of California or for the portion of the program within California. The burden of demonstrating the amount of loss prevention costs, and that those costs are expended for loss prevention in the State of California is on the insurer.

(2) That the insurer should be allowed relief from the efficiency standard due to any or all of the following:

(A) Higher quality of service, as demonstrated by objective measures of consumer satisfaction; or

(B) Demonstrated superior service to underserved communities, as defined in section 2646.6; or

(C) Significantly smaller or larger than average California policy premium, including any applicable fees. These fees include but are not limited to: policy fees, installment fees, endorsement fees, inspection fees,

cancellation fees, reinstatement fees, late fees, SR–22, and other similar charges.

(3) That the insurer should be authorized leverage factor different from the leverage factor determined pursuant to section 2644.17 on the basis that the insurer either writes at least 90% of its direct earned premium in one line or writes at least 90% of its direct earned premium in California and its mix of business presents investment risks different from the risks that are typical of the line as a whole. The leverage factor shall be adjusted by multiplying it by 0.85. The surplus ratio in section 2644.22 shall likewise be divided by 0.85. If an insurer writes at least 90% of its direct earned premium in one line and writes at least 90% of its direct earned premium in California, the insurer will only be authorized one leverage factor adjustment of 0.85.

(4) That the insurer should be granted relief from operation of the efficiency standard for a line of insurance in which the insurer has never previously written over $1 million in earned premiums annually and in which the insurer has made or is making a substantial investment in order to enter the market. Any such request shall be accompanied by a proposed amortization schedule to distribute the start–up investment.

(5) That the minimum permitted earned premium should be lowered on the basis of the insurer's certification, and the Commissioner's finding, that the rate will not cause the insurer's financial condition to present an undue risk to its solvency and will not otherwise be in violation of the law.

(6) That the insurer's financial condition is such that its maximum permitted earned premium should be increased in order to protect the insurer's solvency. Any application for authorization under this subsection shall include:

(A) A showing of the insurer's condition, based on generally accepted standards such as the National Association of Insurance Commissioners' Insurance Regulatory Information System;

(B) A plan to restore the financial condition;

(C) A showing that, consistent with the claimed condition, the insurer has reduced or foregone dividends to stockholders or policyholders; and

(D) A plan to reduce rates once the insurer's condition is restored, in order to compensate consumers for excessive charges.

(7) That the loss development formula in section 2644.6 does not produce an actuarially sound result because

(A) There is not enough data to be credible;

(B) There are not enough years of data to fully calculate the development to ultimate;

(C) There are changes in the insurer's reserving or claims closing practices that significantly affect the data; or

(D) There are changes in coverage or other policy terms that significantly affect the data; or

(E) There are changes in the law that significantly affect the data; or

(F) There is a significant increase or decrease in the amount of business written or significant changes in the mix of business.

(8) That the trend formula in section 2644.7 does not produce the most actuarially sound result because

(A) There is a significant increase or decrease in the amount of business written or significant changes in the mix of business;

(B) There are not enough years of data to calculate the trend factor;

(C) There is a significant change in the law affecting the frequency or severity of claims;

(D) It can be shown that a trend calculated over a period of at least 4 quarters other than a period permitted pursuant to section 2644.7(b) is more reliable prospectively;

(E) There are changes in the insurer's claims closing practices that significantly affect the data; or

(F) There are changes in coverage or other policy terms that significantly affect the data.

(9) That the maximum permitted earned premium would be confiscatory as applied. This is the constitutionally mandated variance articulated in *20th Century v. Garamendi* (1994) 8 Cal.4th 216 which is an end result test applied to the enterprise as a whole. Use of this variance requires a hearing pursuant to 2646.4.

(g) If there is more than one actuarial analysis of a variance, each of which is based on reliable data and utilizes methods which are shown by qualified expert evidence to be generally accepted as sound by the actuarial community and the appropriate methods for the particular variance, then the variance shall be granted, denied or calculated utilizing the actuarial proposition that results in the soundest actuarial result.

(h) Notwithstanding any other section of these regulations, the aggregate total adjustment to the efficiency standard for all variances combined shall not exceed the difference between the insurer's most recent year total expense ratio excluding defense and cost containment expenses and the efficiency standard.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).
2. Amendment filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

§ 2644.28. Prospective Application of Revisions to Regulations.

Any amendment to this subchapter shall only apply prospectively. A rate change application shall be subject to the rules of this subchapter that are in effect on the date the application is received by the Commissioner pursuant to section 1861.05(c) of the Insurance Code.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 5–16–2008; operative 5–16–2008. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2008, No. 20).

Article 4.5. Refiling of Approved Rates

§ 2644.50. Refiling of Approved Rates.

As a means to determine whether a rate previously approved remains in compliance with the statutory standard set forth in California Insurance Code Section 1861.05(a), for an insurer operating with a rate approved three years ago or longer in the homeowners multiple peril and private passenger auto liability and physical damage lines, the Commissioner may require an insurer to file a rate application.

Nothing in this section shall be construed to specify how often an insurer may make a rate application filing.

NOTE: Authority cited: Sections 1857.2, 1857.3, 1861.01, 1861.05 and 12921, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New article 4.5 (section 2644.50) and new section filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

Article 5. Determination of Rates for Rollback Period

§ 2645.1. Scope.

This article applies to all rates charged for insurance issued or renewed on or after November 8, 1988, and not after November 7, 1989.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2645.2. Findings.

The Commissioner finds:

(a) Proposition 103 requires that all rates charged during the rollback period be reduced by 20% from their November 8, 1987, levels. Consumers are entitled to receive, and insurers are obligated to give, this reduction, except to the extent that it violates the insurers' constitutional rights.

(b) Insurers are entitled to rates during the rollback period that are not confiscatory. Rates are confiscatory if and only if all the rates charged by an entire group of insurance companies sharing a single ownership or control are, taken as a whole, confiscatory.

(c) To the extent that the rates specified by Proposition 103 for the rollback period are confiscatory, insurers are entitled to a rate above the level prescribed by the initiative, but no higher than necessary for the rates not to be confiscatory.

(d) Historical data shall be used in lieu of forecasts for the rollback period because actual historical data exist for many of the figures that are forecast in prior–approval ratemaking, making it possible to avoid the errors inherent in forecasting and resulting in greater accuracy.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2645.3. General.

(a) Except as otherwise specified in this article, rates for the rollback period shall be evaluated in the manner specified in article 4 of this subchapter. To the extent that the rates charged during the rollback period exceeded the minimum permitted earned premium, the excess shall be refunded to consumers with interest as set forth in section 2544.9.

(b) Rollback calculations shall be made on an aggregate basis, rather than on a per–exposure basis. Interjurisdictional allocations shall be made as specified in section 2643.6, except that calculations specified in subdivisions (a)(4) and (a)(5) of section 2643.6 shall be made on the basis of earned premium. Leverage factors shall be computed in accordance with section 2644.17.

(c) While premiums paid for surety, credit, and financial guaranty insurance have been exempted by the Legislature from the requirement that they be rolled back, the amount of the rollback due on other property–casualty insurance, to the extent that the rollback is constrained by constitutional limits, is properly determined by evaluating the profitability of all the insurer's California property–casualty insurance not excluded by section 1851 of the Insurance Code. Accordingly, the minimum earned premium shall be calculated on all property–casualty insurance not excluded by section 1851 of the Insurance Code, including surety, credit, and financial guaranty.

(d) The option to disaggregate data within lines as provided by section 2642.7 shall not apply to rollback year calculations.

(e) Minimum permitted earned premium shall be determined on an all–lines combined, groupwide basis.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01, 1861.05, 1861.135, 1861.137 and 12120 of the Insurance Code, *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2645.4. Losses and Allocated Loss Adjustment Expenses.

In lieu of projected losses and loss adjustment expenses, actual loss and loss adjustment expense data for calendar year 1989 shall be used.

(a) Catastrophe adjustment. No adjustment of losses for catastrophes shall be made.

(b) Loss development and trending. Actual incurred losses shall be used, subject to validation by the Commissioner to ensure that there has not been inappropriate reserves–strengthening. Because incurred losses for calendar year 1989 are now known, no loss development is necessary or appropriate and loss and loss adjustment expense trend would have so insubstantial an effect on rates that no adjustment shall be made.

(c) Reserves–strengthening. The Commissioner will not adjust an insurer's 1989 reserves when any of the following conditions are found:

(1) Reserves: Premium, One–Year Test. When the year–end 1989 loss reserves to 1989 earned premiums is less than or equal to the year–end 1989 loss reserves to 1988 earned premiums.

(2) Reserves: Premium Four–Year Test. When the 1989 reserves– to–premium ratio is less than or equal to the average of the reserves–to–premium ratios for 1985 through 1988.

(3) Incurred Versus Paid Test. When the ratio of 1989 incurred losses to 1988 incurred losses was no greater than the ratio of the payments on 1989–incurred losses was to payments on 1988–incurred losses.

(d) If the insurer satisfies none of the three tests in subdivision (c) of this section, unless the Commissioner finds, based on evidence proffered by the insurer and any other party, that some other number better reflects appropriate reserve levels, the insurer's reserves shall be adjusted, on a line–by–line, company–specific basis, to the same multiple of earned premium as the 1985 through 1988 reserves had to 1985 through 1988 earned premium. The adjustment, stated as a formula, is as follows:

$$1989\ \textit{reserves} = 1989\ \textit{earned premium} \left[\frac{1985\text{–}1988\ \textit{reserves}}{1985\text{–}1988\ \textit{earned premium}} \right]$$

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code. Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. New subsections (c) and (d) filed 10–8–91 as an emergency; operative 10–8–91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 2–5–92 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of operative date in HISTORY 2. (Register 92, No. 19).
4. New section filed 2–20–92 as an emergency; operative 2–20–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–19–92 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 2–20–92 order transmitted to OAL 6–19–92 and filed 7–28–92 (Register 92, No. 31).

§ 2645.5. Fixed Expenses.

(a) Executive compensation in excess of the insurer's maximum permissible executive compensation shall be deducted from fixed expenses. For purposes of this computation, the following shall apply:

(1) "Executive" means the insurer's five highest-paid policymaking positions in each insurance group.

(2) "Compensation" means the total cash paid, including salary and bonus.

(3) "Maximum permissible executive compensation" means:

(A) For the highest paid executive in the group:

$$\max comp = 1077(10^{1.4600 + 0.4060 \log X})$$

(B) For the second-highest paid executive in the group:

$$\max comp = 1077(10^{1.4140 + 0.3490 \log X})$$

(C) For the third-highest paid executive in the group:

$$\max comp = 1077(10^{1.2310 + 0.3820 \log X})$$

(D) For the fourth-highest paid executive in the group:

$$\max comp = 1077(10^{1.2470 + 0.3580 \log X})$$

(E) For the fifth-highest paid executive in the group:

$$\max comp = 1077(10^{1.2460 + 0.3420 \log X})$$

where X is the greater of (i) the insurer's total 1989 countrywide direct earned premium for lines of business subject to Proposition 103 divided by 1,000,000 or (ii) 70.

(b) For rollback calculations, fixed expenses for each line shall be set at the lower of the quantity specified in section 2644.12, subdivision (a), or actual recorded expenses for calendar year 1989. For rollback calculations the term "maximum profit factor" in section 2644.12 means "profit factor" as defined in section 2645.6.

(c) For rollback calculations, the following table shall be used to determine the efficiency standard:

Line	*Captive Writer*	*Direct Writer*	*Independ Agency*
Fire	41.50%	28.83%	41.88%
Allied Lines	36.65%	29.54%	33.20%
Farmowners Multiple Peril	36.16%	36.16%	36.16%
Homeowners Multiple Peril	32.77%	24.28%	40.86%
Commercial Multiple Peril	34.02%	30.13%	39.59%
Inland Marine	32.91%	33.99%	33.10%
Financial Guaranty	15.01%	15.01%	15.01%
Medical Malpractice	18.36%	18.36%	18.36%
Earthquake	41.13%	17.35%	30.94%
Other Liability	35.01%	14.92%	28.63%
Pvt Pass Auto Liability	27.01%	19.01%	33.16%
Comml Auto Liab	33.86%	19.78%	31.63%
Pvt Pass Auto Phys Damage	27.13%	19.87%	34.49%
Comml Auto Phys Damage	31.81%	17.04%	35.97%
Aircraft	24.07%	29.22%	24.27%
Fidelity	26.84%	26.84%	26.84%
Surety	42.56%	51.77%	53.76%
Glass	39.97%	39.97%	39.97%
Burglary & Theft	27.48%	27.48%	27.48%
Boiler & Machinery	27.86%	31.76%	52.54%
Credit	44.69%	44.69%	44.69%

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code. Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8-13-91 as an emergency; operative 8-13-91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12-11-91 or emergency language will be repealed by operation of law on the following day.
2. New subsections (a) and (c) filed 10-8-91 as an emergency; operative 10-8-91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 2-5-92 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of file and operative dates in HISTORY 2. (Register 92, No. 19).
4. New section filed 2-20-92 as an emergency; operative 2-20-92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6-19-92 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 2-20-92 order transmitted to OAL 6-19-92 and filed 7-28-92 (Register 92, No. 31).

§ 2645.6. Profit Factor.

(a) The after-tax rate of return for property and casualty insurance, corresponding to the lower boundary of the range of reasonable returns, is 10.0 percent.

(b) For the rollback period, leverage factor for each line shall be determined on a groupwide basis from the following table:

[The next page is 728.33.]

Line	*Leverage Ratio*
Fire	3.50:1
Allied Lines	3.50:1
Farmowner Multiple Peril	2.50:1
Homeowner Multiple Peril	2.50:1
Commercial Multiple Peril	1.75:1
Inland Marine	3.50:1
Medical Malpractice	1.00:1
Earthquake	2.00:1
Other Liability	1.00:1
Private Passenger Auto Liability	2.00:1
Commercial Auto Liability	2.00:1
Private Passenger Auto Physical Damage	5.50:1
Commercial Auto Physical Damage	5.50:1
Aircraft	1.00:1
Fidelity	2.00:1
Glass	5.50:1
Burglary & Theft	4.00:1
Boiler & Machinery	2.50:1

(c) To the extent that an insurer has operated during calendar–year 1989 on less surplus than the leverage factor would prescribe, the insurer's actual leverage ratio shall be used. The insurer's actual leverage ratio shall be computed by allocating the insurer's surplus to lines in proportion to the insurer's average 1989 reserves as specified in section 2644.21.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code. Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Amendment of subsection (a), new subsection (b) and renumbering filed 10–8–91 as an emergency; operative 10–8–91 (Register 92, No. 13). A Certificate of Compliance must be transmitted to OAL 2–5–92 or emergency language will be repealed by operation of law on the following day.
3. New section filed 2–20–92 as an emergency; operative 2–20–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–19–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–20–92 order transmitted to OAL 6–19–92 and filed 7–28–92 (Register 92, No. 31).

§ 2645.7. Credibility.

No adjustment shall be made for credibility in rollback calculations.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2645.8. Investment Income.

The insurer's imbedded yield, plus the five–year average (1985 through 1989) of realized capital gains, shall be used in lieu of the projected yield. Imbedded yield shall be calculated as the insurer's net investment income, excluding capital gains, divided by the average of the insurer's year–end surplus and reserves for 1988 and 1989. The insurer's five–year average realized capital gains shall be calculated as the mean of the quotients, for each year 1985 through 1989, of the annual realized capital gains and the average of the insurer's year–end surplus and reserves for that year and the previous year.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2645.9. Amount of Refund.

(a) "Statutory percentage" means the larger of

(1)(A)(i) total 1989 direct premium earned, excluding surety, credit, and financial guaranty insurance,

(ii) minus total 1989 direct premium earned, excluding surety, credit, and financial guaranty insurance, adjusted to be on the rate level of November 8, 1987, multiplied by 0.8,

(B) divided by total 1989 direct premium earned, excluding surety, credit, and financial guaranty insurance, or

(2) zero.

(b) "Constitutional percentage" means the larger of

(1)(A)(i) total 1989 direct premium earned, including surety, credit, and financial guaranty insurance,

(ii) minus the minimum permitted earned premium, including surety, credit, and financial guaranty insurance,

(B) divided by total 1989 direct premium earned, excluding surety, credit, and financial guaranty insurance, or

(2) zero.

(c) "Refund percentage" means the lesser of the statutory percentage and the constitutional percentage.

(d) For purposes of determining the insurer's rollback obligation, policyholder dividends paid during calendar year 1989 by the insurer shall be treated as follows:

(1) as a refund of premium to the extent that they do not exceed the average dividend, computed as a percent of earned premium, paid in calendar years 1986 through 1988;

(2) as a voluntary rollback and a credit against the rollback obligation owed to consumers who received the dividend to the extent that the dividends exceed the amount specified in subparagraph (1), above.

(e) Each person from whom premiums were collected for policies issued or renewed during the rollback period for coverages other than surety, credit, or financial guaranty insurance shall receive the amount equal to the premiums paid on such policies multiplied by the refund percentage. To this amount shall be added interest, calculated at 10% per annum, from May 8, 1989, to the date of payment.

(f) Every insurer ordered to make a rollback refund shall, on the first three anniversaries of the date of the order, file a report with the Department of Insurance showing the status of the refund payments.

(g) The Commissioner shall require the insurer to file periodic reports establishing its diligent efforts to deliver the refund to each person entitled to a refund before the refund becomes subject to the Unclaimed Property Law, Code of Civil Procedure section 1500 et seq. The Commissioner shall require that the periodic reports be filed quarterly unless the Commissioner finds that more frequent reports are necessary to ensure compliance.

NOTE: Authority cited: Sections 1861.01, 1861.05, 1861.135, 1861.137 and 12120 of the Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; section 1500 et seq. of the Code of Civil Procedure; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).

3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

Article 6. Procedures for Determination of Rates

§ 2646.1. Hearings.

(a) Except under extraordinary circumstances, as found by the Commissioner or administrative law judge, direct testimony shall be given in writing and shall not be delivered orally. Where a party has shown that the purposes of the Administrative Procedure Act, Government Code section 11500 et seq., would be frustrated by requiring it to provide a witness' testimony in writing, that witness shall be permitted to give his or her direct testimony orally.

(b) The Commissioner or administrative law judge may limit the time for oral examination, may curtail repetitive arguments, and may require persons representing common positions to coordinate their presentations and to designate a common representative. In the interest of time, and consistent with the Administrative Procedure Act, Government Code section 11500 et seq., the Commissioner or administrative law judge may require matters to be submitted in writing in lieu of oral proceedings. Where necessary to a timely decision, the Commissioner or administrative law judge may direct that oral examination of witnesses be conducted by deposition and introduced in the record in writing, subject to the objections of all parties.

(c) Any order to expedite proceedings, such as by simultaneous examination of witnesses by deposition rather than in the hearing, shall not be entered without first giving due consideration to the effects on parties that may lack the resources to participate on such an expedited basis.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01, 1861.05 and 1861.08 of the Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2646.2. Certification of Questions to the Commissioner.

(a) In any hearing before an administrative law judge, the administrative law judge may, on the motion of any party or on his or her own motion, certify a question to the Commissioner for determination during the proceedings before the administrative law judge.

(b) Certification shall be limited to matters that either (1) apply to numerous pending hearings; (2) are substantially in doubt and are so fundamental to the instant proceeding that absent certification there is a substantial risk that hearing time would be wasted; or (3) in the opinion of the administrative law judge, require immediate determination by the Commissioner in the interests of justice.

(c) The Commissioner may decline to answer the certified question without specifying any grounds. Denial of certification without reaching the merits is without prejudice to the party's right to raise the matter before the administrative law judge or the Commissioner.

NOTE: Authority cited: Sections 1861.01, 1861.05 and 1861.055, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216, 281 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805; and *Fireman's Fund Insurance Companies* v. *Charles Quackenbush* (1997) 52 Cal.App.4th 599, 607.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Repealer of subsection (d) and amendment of NOTE filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2646.3. Generic Determinations.

(a) "Generic determination" means a finding the Commissioner is required or authorized by these regulations to make, which finding is intended to apply to the rate applications of several or all insurers.

(b) The generic determination shall be adopted as a regulation pursuant to chapter 3.5 (sections 11340 through 11356 of the Government Code), upon final decision of the Commissioner, and shall be binding in hearings on individual insurers' rates.

(c) In a hearing convened for the purpose of making a generic determination, any person may propose that the pertinent data be disaggregated by geographic region, policy limits and deductibles, or amount of premium the insurer writes in the line and that separate determinations be made for each category. This subsection does not authorize insurer–by–insurer generic determinations.

(d) The Commissioner may, from time to time, review generic determinations to assess whether they are still sound. Such review may be on the Commissioner's own motion or on the petition of any person. Any such petition shall specify the changes in circumstances giving rise to the need for a revised determination.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of subsection (b) and repealer of subsections (e)–(e)(2) filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2646.4. Hearings on Individual Insurers' Rates.

(a) This section applies to any request for a hearing on an individual insurer's rates, and applies to both requests made prior to a rate becoming effective and to requests concerning a rate in effect.

(1) A request for a hearing on a rate application shall be either delivered or mailed to the Department of Insurance within 45 days of the public notice specified in subdivision (c) of Insurance Code section 1861.05.

(2) A request for a hearing at any other time shall be based on the allegation that, pursuant to subdivision (a) of Insurance Code section 1861.05, a rate is "in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of" chapter 9 (commencing with section 1851) of part 2 of division 1 of the Insurance Code.

(b) A hearing on a rate application, and a hearing based on the allegation that a rate in effect is excessive, inadequate, unfairly discriminatory or otherwise in violation of chapter 9 (commencing with section 1851) of part 2 of division 1 of the Insurance Code shall be for the purpose of determining whether

(1) the insurer has properly applied the statute and these regulations in calculating the maximum or minimum permitted earned premium; or

(2) the maximum permitted earned premium or minimum permitted earned premium calculated on the basis of the statute and these regulations, should be adjusted as provided in section 2644.27. A request that the maximum permitted earned premium or minimum permitted earned premium should be adjusted is referred to as a "variance request."

(c) Relitigation in a hearing on an individual insurer's rates of a matter already determined either by these regulations or by a generic determination is out of order and shall not be permitted. However, the administrative law judge shall admit evidence he or she finds relevant to the determination of whether the rate is excessive or inadequate (or, in the case of a proceeding under Article 5, relevant to the determination of the minimum nonconfiscatory rate), whether or not such evidence is expressly contemplated by these regulations, provided the evidence is not offered for the purpose of relitigating a matter already determined by these regulations or by a generic determination.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; and *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).
5. Amendment of subsections (b)(1) and (b)(2), repealer of subsections (c)–(d) and subsection relettering filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

§ 2646.5. Burden of Proof.

The insurer has the burden of proving, by a preponderance of the evidence, every fact necessary to show that its rate is not excessive, inadequate, unfairly discriminatory, or otherwise in violation of chapter 9 (commencing with section 1851) of part 2 of division 1 of the Insurance Code.

NOTE: Authority cited: Sections 1861.01 and 1861.05, Insurance Code; *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 1861.01 and 1861.05, Insurance Code; *Calfarm Insurance Company* v. *Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmittted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) and new section filed 3–15–95; operative 3–15–95. Submitted to OAL for printing only pursuant to Government Code section 11343(a)(1) (Register 95, No. 11).

§ 2646.6. Commissioner's Report on Underserved Communities.

Definitions

For the purpose of these regulations, the following terms are construed as defined herein:

"Insurer" means those carriers admitted to transact the business of insurance in California and the California Fair Access to Insurance Requirements (FAIR) Plan.

"Underserved Community" means those communities which the Commissioner has determined are underserved as set forth in the "Commissioner's Report on Underserved Communities".

(a) Each insurer writing in any one of the lines of insurance set forth in Section 2646.6(b)(1)(A) through (D) below, with the exception of umbrella, excess or reinsurance coverages, shall compile and maintain, by experience year the information required by this section for that line of business, on or before March 1 of every year each insurer writing the coverages listed in (b)(1) below shall file a Community Service Statement with the Department of Insurance's Statistical Analysis Bureau in Los Angeles. The Community Service Statement shall contain a verification of an executive officer of the insurer, under penalty of perjury under the laws of the State of California, that the information contained therein is true and correct.

(b) Such information shall be compiled and maintained in a manner which will allow the insurer to report the information to the Commissioner for each Zone Identification Program ("ZIP") code in every county in California in which the insurer sells insurance or maintains agents:

(1) Premium Written & Earned; Exposure Written & Earned;

(A) private passenger automobile liability (including policies issued through the California Automobile Assigned Risk Plan);

(B) homeowners multiple peril (including policies submitted to, and/or gathered by the California FAIR Plan);

(C) commercial multiple peril, by ZIP code for the location of individual risks;

(D) fire (commercial and personal lines fire coverages should be maintained and compiled in such a manner as to allow them to be reported separately) including policies submitted to, and/or gathered by the California FAIR Plan;

(2) the Community Service Statement shall contain the number of service offices maintained in the ZIP code during the reporting period; (For purposes of this section, "service" means claims service, and sales service.) Where more than one service is performed at an office, the insurer shall categorize the office based upon the service or services provided at that office.

(3) the number of independent, employed or captive agents or agencies in the ZIP code during the reporting period;

To be counted for purposes of this section, an office must be open to the general public no fewer than 37.5 hours per week at least 50 weeks per year. A new office opened at any time during the reporting period shall be counted if it has been open at least 60 consecutive business days during the reporting period. An office closed at any time during the reporting period shall be counted unless it has been closed for more than 60 consecutive business days during the reporting period.

(4) for an insurer distributing through direct solicitation, the number of direct mail and telephone solicitations for new insurance business made during the reporting period to addresses in the ZIP code; the number of agents maintaining offices in the ZIP code during the reporting period who identified themselves as conversant in a language other than English, listed by language as specified below:

(1) Spanish
(2) Chinese
(3) Japanese
(4) Filipino
(5) Korean
(6) Vietnamese
(7) Other than English (includes those above and those not listed)

(6) the race or national origin, and gender, of each policyholder who is a natural person, as provided by the policyholder on a separate, detachable form that refers to the application. The form shall state that this information is requested by the State of California in order to monitor the insurer's compliance with the law, that the policyholder is not required to provide this information but is encouraged to do so, and that the insurer may not use this information for underwriting or rating purposes. The Department's form is available on the Department's website. No such information shall be used for purposes of underwriting or rating any applicant.

For purposes of this section, race or national origin means one of the following:

(A) American Indian or Alaskan Native
(B) Asian or Pacific Islander
(C) African–American
(D) Latino
(E) White
(F) Other
(G) Information not provided by policyholder.

(c) The Community Service Statement shall be subject to California Insurance Code section 1861.07 and the Commissioner shall, every year as soon as the information is available, issue the Commissioner's Report on Underserved Communities which will report those communities within California, designated by ZIP code, that the Commissioner finds to be underserved by the insurance industry. A community shall be deemed to be underserved by the insurance industry if the Commissioner finds:

(1)(A) the proportion of uninsured motorists is ten percentage points above the statewide average as reflected in the most recent Department of Insurance statistics regarding the statewide average of uninsured motorists; and

(B) the per capita income of the community, as measured in the most recent U.S. Census, is below the fiftieth percentile for California; and

(C) the community, as measured in the most recent U.S. Census, is predominately minority. Predominately minority community can be quantified as any community that is composed of two–thirds or more minorities as those groups are defined in subsection (b)(6)(A) through (D) herein; or

(2) the proportion of uninsured businesses or residences is ten percentage points above the statewide and/or Standard Metropolitan Statistical Area ("SMSA") average as determined by the Commissioner following a public hearing convened for the purpose of determining the number of uninsured businesses or residences in this state.

(d) The Commissioner's Report on Underseved Communities shall list for each insurance company doing business in California:

(1) the number and percentage of total exposures the company has in force insuring risks in the underserved communities and in all other communities, stated separately by line as listed in (b)(1) above;

(2) the number and percentage of offices maintained in the underserved communities and in all other communities

(3) for an insurer distributing principally through means other than direct solicitation, the number and percentage of its agents maintaining offices in the underserved communities and in all other communities

(e) The remedies in this section are in addition to any other remedy available to the Commissioner or to any other person.

NOTE: Authority cited: Sections 12921 and 12926, Insurance Code; *CalFarm v. Deukmejian*, 48 Cal.3d 805 (1989). Reference: Sections 679.71, 1861.02, 1861.03, 1861.05 and 11628, Insurance Code.

HISTORY

1. New section filed 4–20–94; operative 5–20–94 (Register 94, No. 16).
2. Change without regulatory effect adding new subsections (b)(3) and (e)(3) and subsection renumbering, and amendment of newly designated subsection (b)(6) filed 10–7–94 pursuant to section 100, title 1, California Code of Regulations (Register 94, No. 40).
3. Editorial correction of subsection (e)(3) (Register 96, No. 19).
4. Amendment of subsections (a) and (b), repealer of and new subsection (b)(1), amendment of subsections (b)(1)(D)–(b)(1)(G), repealer of subsection (b)(1)(H) and subsection relettering, amendment of newly designated subsection (b)(1)(H) and subsections (b)(2)–(b)(6) and (b)(6)(F), new subsection (b)(7) and subsection renumbering, and amendment of subsections (c) and (e) filed 5–6–96; operative 5–6–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 19).
5. New section heading and definitions, amendment of subsection (a) and repealer of subsection (f) and subsection relettering filed 5–15–96; operative 6–14–96 (Register 96, No. 20).
6. Amendment of subsection (a) and repealer of paragraph following (b)(8) filed 6–4–96; operative 6–14–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 23).
7. Amendment filed 2–11–2003; operative 3–15–2003 (Register 2003, No. 7).

§ 2646.7. Strategic Plans for Underserved Communities.

NOTE: Authority cited: California Insurance Code Sections 12921 and 12926; *CalFarm v. Deukmejian*, 48 Cal.3d 805 (1989); Reference: California Insurance Code Sections 679.71, continually 1861.02, 1861.03, 1861.05 and 11628.

HISTORY

1. New section filed 5–15–96; operative 6–14–96 (Register 96, No. 20).
2. Repealer filed 2–11–2003; operative 3–15–2003 (Register 2003, No. 7).

§ 2646.8. Submission of Evidence Demonstrating an Existing Presence in Underserved Communities.

NOTE: Authority cited: California Insurance Code Sections 12921 and 12926; *CalFarm v. Deukmejian*, 48 Cal.3d 805 (1989); Reference: California Insurance Code Sections 679.71, continually 1861.02, 1861.03, 1861.05 and 11628.

HISTORY

1. New section filed 5–15–96; operative 6–14–96 (Register 96, No. 20).
2. Repealer filed 2–11–2003; operative 3–15–2003 (Register 2003, No. 7).

§ 2646.9. Consumer Participation in the Commissioner's Decision to Accept or Reject a Strategic Plan for Underserved Communities or Evidence Demonstrating an Existing Presence.

NOTE: Authority cited: California Insurance Code Sections 12921 and 12926; *CalFarm v. Deukmejian*, 48 Cal.3d 805 (1989); Reference: California Insurance Code Sections 679.71, continually 1861.02, 1861.03, 1861.05 and 11628.

HISTORY

1. New section filed 5–15–96; operative 6–14–96 (Register 96, No. 20).
2. Repealer filed 2–11–2003; operative 3–15–2003 (Register 2003, No. 7).

§ 2646.10. Timelines for Commissioner's Review; Procedures for Submission of Corrective Plans or Revised Evidence.

NOTE: Authority cited: California Insurance Code Sections 12921 and 12926; *CalFarm v. Deukmejian*, 48 Cal.3d 805 (1989); Reference: California Insurance Code Sections 679.71, continually 1861.02, 1861.03, 1861.05 and 11628.

HISTORY

1. New section filed 5–15–96; operative 6–14–96 (Register 96, No. 20).
2. Repealer filed 2–11–2003; operative 3–15–2003 (Register 2003, No. 7).

§ 2646.11. Failure to Comply with Provisions of an Accepted Strategic Plan for Underserved Communities or Material Misstatement of Evidence Demonstrating an Existing Presence.

NOTE: Authority cited: California Insurance Code Sections 12921 and 12926; *CalFarm v. Deukmejian*, 48 Cal.3d 805 (1989); Reference: California Insurance Code Sections 679.71, continually 1861.02, 1861.03, 1861.05 and 11628.

HISTORY

1. New section filed 5–15–96; operative 6–14–96 (Register 96, No. 20).
2. Repealer filed 2–11–2003; operative 3–15–2003 (Register 2003, No. 7).

Article 7. Cost of Administration

§ 2647.1. Costs of Administration and Operation.

(a) For purposes of this section, "insurer" means every person holding a certificate of authority and writing insurance on risks on operations in this state, except those insurers exclusively writing insurance on lines or classes specified in section 1851 of the Insurance Code, including credit, and financial guaranty insurance.

(b) Fees assessed and collected pursuant to this section shall be deposited in a sub–account within the Insurance Fund ("the Sub–Account"), for the sole purpose of collecting and disbursing funds for the administrative and operational costs arising from the provisions of article 10 of division 1, part 2, chapter 9 of the Insurance Code.

(c) Each insurer shall be assessed, and shall pay, in quarterly installments as specified in this section, an annual fee, in the amount determined as specified in this section, for each line of insurance written in California (including surety, credit, and financial guaranty insurance), excluding policies written in lines or classes specified in section 1851 of the Insurance Code.

(1) The Department shall adopt a Base Rate, which shall be calculated to produce a total assessment equal to the appropriation contained in the State Budget for the administrative and operational costs arising from the provisions of article 10 of division 1, part 2, chapter 9 of the Insurance Code, plus or minus such amounts as the Commissioner deems necessary as a contingency against unanticipated fluctuations in expenditures and revenues and plus or minus such amounts as the Commissioner deems

necessary to correct for over–collections or under–collections in prior years. The Base Rate shall reflect any revenues, other than revenues from the assessment specified in this section, which revenues are properly attributable to the administrative and operational costs arising from the provisions of article 10 of division 1, part 2, chapter 9 of the Insurance Code.

(2) The amount of fee shall be based on the insurer's California derived direct premiums written in the calendar year preceding the first day of the fiscal year in which the assessment is made, calculated by annual statement line of insurance.

(3) For each line of insurance, the assessment shall equal the Base Rate multiplied by the Assessment Factor contained in the following table:

For Each Line in Which the Derived Direct Written Premiums Were Greater Than	*And Less Than or Equal to*	*Assessment Factor*
$0	$250,000	1.0
250,000	500,000	2.0
500,000	1,000,000	4.0
1,000,000	2,000,000	7.0
2,000,000	4,000,000	14.0
4,000,000	7,000,000	25.0
7,000,000	12,000,000	35.0
12,000,000	20,000,000	50.0
20,000,000	30,000,000	70.0
30,000,000	45,000,000	100.0
45,000,000	65,000,000	140.0
65,000,000	100,000,000	180.0
100,000,000	150,000,000	250.0
150,000,000	250,000,000	360.0
250,000,000		500.0

(d) Each quarterly installment shall be in the amount of one–quarter of the annual fee, except when the Commissioner determines that it is necessary, due to operational requirements and the timing of liabilities, to collect more than one–quarter of the annual fee in a given quarter, in which case the installment may be in an amount no greater than one–half of the annual fee, provided that in no event shall the sum of the quarterly installment exceed the annual fee.

(e) If, at the end of any fiscal year, the Sub–Account contains a surplus in excess of 25 percent of the administrative and operational costs arising from the provisions of article 10 of division 1, part 2, chapter 9 of the Insurance Code, as determined from the prior year's actual costs and any budgeted additional or reduced costs, the Commissioner shall credit the amount in excess of 25 percent against future assessments and shall review the Base Rate to determine whether an adjustment is necessary to reduce the surplus in the Sub–Account to no more than 25 percent of the expected annual administrative and operational costs arising from the provisions of article 10 of division 1, part 2, chapter 9 of the Insurance Code.

NOTE: Authority cited: Sections 1861.01, 1861.05, 12979 and 12992, Insurance Code. Reference: Section 12979, Insurance Code; and *Calfarm Insurance Company v. Deukmejian* (1989) 48 Cal.3d 805.

HISTORY

1. New section filed 8–13–91 as an emergency; operative 8–13–91 (Register 92, No. 3). A Certificate of Compliance must be transmitted to OAL 12–11–91 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 92, No. 15).
3. New section refiled 2–14–92 as an emergency; operative 2–14–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 6–15–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–14–92 order transmitted to OAL 7–27–92 and filed 7–27–92 (Register 92, No. 31).
5. Amendment of subsection (a), repealer of subsection (b), and amendment of new subsections (b)–(e) and NOTE filed 9–11–95 as an emergency; operative 9–11–95 (Register 95, No. 37). A Certificate of Compliance must be transmitted to OAL by 1–9–96 or emergency language will be repealed by operation of law on the following day.
6. Reinstatement of section as it existed prior to emergency amendment filed 9–11–95 by operation of Government Code section 11346.1(f) Register 96, No. 14).
7. Amendment of section heading and subsection (a), repealer of subsection (b), new subsections (b)–(e) and amendment of NOTE filed 4–1–96 as an emergency; operative 4–1–96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–96 or emergency language will be repealed by operation of law on the following day.
8. Editorial correction of NOTE (Register 96, No. 18).
9. Certificate of Compliance as to 4–1–96 order, including amendment of subsection (a), transmitted to OAL 3–20–96 and filed 5–1–96 (Register 96, No. 18).

Article 8. Timelines for Scheduling and Commencing Hearings.

§ 2648.1. Scope.

(a) Except as provided for herein, this article applies to proceedings commenced by the issuance of a notice of hearing, or other notice or order commencing a proceeding on a rate application issued by the Commissioner pursuant to Insurance Code Section 1861.05, subdivision (c).

(b) This article shall not apply to applications for exemption from Insurance Code Section 1861.01(a), file and use rate applications filed prior to November 8, 1989, or applications for rate changes pursuant to Insurance Code Section 1861.05 which are filed prior to July 1, 1993. Refiling of applications for rate changes pursuant to Insurance Code Section 1861.05 shall be made by filing the Department cover sheet entitled "Cover Sheet for Re–Filing of Application for Approval of Insurance Rates," Department form number CA–RA1, dated May 1, 1993, which is incorporated by reference. In addition, for those applications which were submitted with data that is no longer current, updated data must also be submitted with the cover sheet.

NOTE: Authority cited: Sections 1861.05 and 1861.055 California Insurance Code. Reference: Sections 1861.05 and 1861.055, California Insurance Code.

HISTORY

1. New article 8 (sections 2648.1–2648.4) filed 7–12–93 as an emergency; operative 7–12–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL 11–8–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–12–93 order including amendment of subsection (b) transmitted to OAL 11–3–93 and filed 12–17–93 (Register 93, No. 51).

§ 2648.2. Receipt of Rate Change Application By Commissioner.

(a) For the purpose of Insurance Code Section 1861.05(c), a rate change application shall be considered to have been received by the Commissioner on the date that it is received by the Department's Rate Filing Bureau in San Francisco.

(b) Within 14 days of receipt, the Commissioner shall review rate applications for completeness as required by Insurance Code Section 1861.05(b). If the application includes the forms and exhibits listed in the Filing Checklist, as provided in Section 2648.4, and the data required therein, it is complete. If the Commissioner determines that the application is not complete because it does not include such forms, exhibits, or the data required therein, notice stating the grounds for incompleteness will be given to the insurer within the 14 day period and the application will be rejected. Within 10 days of the date that such notice is given, the insurer may request a hearing on the rejection.

(c) The hearing shall be held within 10 days of receipt of the request by the Department's Rate Enforcement Bureau. The scope of the hearing shall be limited to the completeness of the application.

(d) If, after a hearing, an application is determined to have been complete when filed, then the 180 day period specified in Insurance Code Section 1861.05 shall have commenced on the date the application was first filed. If the application is determined to be incomplete, then it shall remain rejected.

(e) Rejection of an application for incompleteness shall not bar the refiling of a complete application.

(f) Public notice required by Insurance Code Section 1861.05 shall be made within 10 days after the Commissioner determines that an application is complete.

NOTE: Authority cited: Sections 1861.05 and 1861.055, California Insurance Code. Reference: Sections 1861.05 and 1861.055, California Insurance Code.

HISTORY

1. New section filed 7–12–93 as an emergency; operative 7–12–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL 11–8–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–12–93 order transmitted to OAL 11–3–93 and filed 12–17–93 (Register 93, No. 51).

§ 2648.3. Scheduling Conference.

(a) If the Commissioner decides to hold a hearing pursuant to Insurance Code Section 1861.05, a notice of hearing, or other notice or order commencing a proceeding under Insurance Code Section 1861.05., shall be provided within 60 days after public notice has been given. After such notice has been issued, and within 20 days after the time for filing a notice of defense or other response by respondent as provided for in Government Code Section 11506, the administrative law judge assigned to hear the matter, or the Commissioner if no judge has been assigned, shall give written notice of a scheduling conference to all parties to the proceeding and to all persons having advised the Commissioner of an interest in intervening in the proceeding. The notice shall provide that the scheduling conference shall be held within 30 days of the date of said notice.

(b) The scheduling conference shall consider such issues as may be raised by the administrative law judge, the parties, or persons interested in intervening in the proceeding, including the following: the scope of issues; the scope of discovery that has been conducted and the scope of anticipated discovery; discovery schedule; schedule for bringing motions; schedule for submission of prefiled testimony; matters pertaining to intervention; the date for the evidentiary hearing.

(c) During the scheduling conference, the administrative law judge shall set a date for commencement of the evidentiary hearing that is less than 180 days from the date the application was received by the Department.

(d) Upon good cause shown during the scheduling conference, or upon subsequent motion, the date for the evidentiary hearing may be set or continued, to a date that is more than 180 days from the date the application was received by the Department. In determining the existence of good cause, the administrative law judge may consider any pertinent matter. A continuance may be granted if the party seeking the continuance is not responsible for and made a good faith effort to prevent the condition or event establishing good cause.

NOTE: Authority cited: Sections 1861.05 and 1861.055, California Insurance Code. Reference: Sections 1861.05 and 1861.055, California Insurance Code.

HISTORY

1. New section filed 7–12–93 as an emergency; operative 7–12–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL 11–8–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–12–93 order including amendment of subsection (d) and NOTE transmitted to OAL 11–3–93 and filed 12–17–93 (Register 93, No. 51).

§ 2648.4. Complete Application.

(a) In order to be complete, a rate application must include the following forms, exhibits, data and documentation, which are incorporated by reference: application for approval (form CA–RA1, 5–1–96 ed.), duplicate of form CA–RA1 for return copy, self–addressed envelope with sufficient postage to return the duplicate copy of CA–RA1, Rate/Rule/Underwriting Rule Submission Data Sheet (form CA–RA2, 5–1–96 ed.), Line of Business (form CA–RA3, 5–1–96 ed.), Filing Checklist (form CA–RA4, 5–1–96 ed.), Ratemaking Data (form CA–RA5, 5–1–96 ed.), Reconciliation Report (form CA–RA6, 5–1–96 ed.), Additional Data Required by Statute (form CA–RA7, 5–1–96 ed.), Miscellaneous Data (form CA–RA8, 5–1–96 ed.), Filing History (to be labeled Exhibit 1), Rate Level History (to be labeled Exhibit 2), Premium Adjustment Factor (to be labeled Exhibit 3), Premium Trend Factor (to be labeled Exhibit 4), Allocated Loss Adjustment Expense (to be labeled Exhibit 5), Loss Development Factors (to be labeled Exhibit 6), ALAE Development Factors (to be labeled Exhibit 7), Loss Trend, ALAE Trend, and Expense Trend (to be labeled Exhibit 8), Catastrophe Adjustment (to be labeled Exhibit 9), Policy Term Distribution (to be labeled Exhibit 10), Credibility Adjustment (to be labeled Exhibit 11), Data Availability Report (to be labeled Exhibit 12), Interjurisdictional Expense Allocations (to be labeled Exhibit 13), Unallocated Loss Adjustment Expense (to be labeled Exhibit 14), Other Expense Items (to be labeled Exhibit 15), Ancillary Income (to be labeled Exhibit 16), Federal Income Tax Rate (to be labeled Exhibit 17), Projected Investment Income Ratio (to be labeled Exhibit 18), Loss Reserves, Loss Adjustment Expense Reserves, and Unearned Premium Reserves (to be labeled Exhibit 19), Insurer's Ratemaking Calculations (to be labled Exhibit 20), Rate Distribution (to be labeled Exhibit 21), Rate Classification Relativities (to be labeled Exhibit 22), New Program (to be labeled Exhibit 23), Group Filing (to be labeled Exhibit 24), rating rules, and rate pages. The application must also contain a summary and explanation of the purpose for the filing. The Filing Instructions (forms CA–IA1—CA–I8, 5–1–96, ed.) for these forms and exhibits are incorporated by reference.

(b) Notwithstanding the completeness determination, the Commissioner may later require the submission of relevant underwriting rules and other relevant documents from an applicant in order to perform a complete analysis of an application.

(c) Requests for variances as authorized by section 2644.27 shall be on the following form:

STATE OF CALIFORNIA — Insurer Name
DEPARTMENT OF INSURANCE — Line of Business

Request for Variance

1. Identify each variance requested.
2. Identify the extent or amount of the variance requested and the applicable efficiency standard, rate of return, loss development factors or trend which will result if the variance is granted.
3. Set forth the expected result or impact on the maximum and minimum permitted earned premium that the granting of the variance will have as compared to the expected result if the variance is denied.
4. Identify the facts and their source justifying the variance request and provide the documentation supporting the amount of the change in the applicable efficiency standard, rate of return, loss development factors or trend that is being proposed.

xx–xx–06 ed. CA–RA9

NOTE: Authority cited: Sections 1861.01 and 1861.055, Insurance Code. Reference: Sections 1861.05, 1861.07 and 1861.055, Insurance Code.

HISTORY

1. New section filed 7–12–93 as an emergency; operative 7–12–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL 11–8–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–12–93 order including amendment of subsection (a) and NOTE transmitted to OAL 11–3–93 and filed 12–17–93 (Register 93, No. 51).
3. Change without regulatory effect amending subsection (a) filed 5–15–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 20).
4. Amendment of subsection (b) filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).
5. New subsection (c) and amendment of NOTE filed 1–3–2007; operative 4–3–2007. Submitted to OAL for printing only pursuant to Government Code section 11340.9(g) (Register 2007, No. 1).

Subchapter 4.9. Rules of Practice and Procedure for Rate Proceedings

Article 1. Preamble

§ 2649.1. Scope.

This subchapter sets forth the rules of practice and procedure governing proceedings conducted pursuant to Article 10 of Chapter 9 of Part 2 of Division 1 of the California Insurance Code, entitled "Reduction and Control of Insurance Rates."

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th*

Century Insurance Company v. John Garamendi, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055, 1861.08 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New subchapter 4.9, article 1 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

Article 2. Responsibilities of Parties

§ 2650.1. Responsibilities of Parties.

(a) Any person representing a party in a proceeding as defined in section 2651.1 shall, no later than the next appearance of that party, file and serve notification of that representation to all other parties.

(b) Any party who has initiated or intervened in any proceeding as defined in section 2651.1 shall, within five (5) days of determining to withdraw from participation in the proceeding, file and serve notification of that fact to all other parties.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 2 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

[The next page is 728.37.]

Article 3. Definitions

§ 2651.1. Definitions.

The following definitions shall apply to Subchapter 4.9.

(a) "Administrative Hearing Bureau" means that office within the office of the Commissioner at 45 Fremont Street, 22nd Floor, San Francisco, CA 94105 and, except where otherwise specified in this subchapter, designated for receipt of all pleadings filed pursuant to this subchapter.

(b) "Applicant" means the insurer presenting, on the form prescribed by the Commissioner and specified in section 2648.4, an application to change any rate pursuant to California Insurance Code section 1861.05(b).

(c) "Application" means the form prescribed by the Commissioner and specified in section 2648.4, together with all supporting information included with that form, which every insurer seeking to change any rate pursuant to California Insurance Code section 1861.05(b) must provide.

(d) "Day", unless otherwise specified in these regulations, means a calendar day. "Business days" include all days except Saturdays, Sundays, and any holiday set forth in California Government Code section 6700.

The time within which any pleading may be filed or served shall exclude the first day and include the last day; however, when the last day falls on a Saturday, Sunday or holiday the time computation shall exclude that day and include the next business day.

(e) "Filing" means the act of delivery of a paper pleading to the Administrative Hearing Bureau. An original and four copies of each pleading shall be filed with the Administrative Hearing Bureau. A specific pleading may be filed by facsimile or electronic transmission only when authorized by the administrative law judge.

(f) "Party" means the insurer whose rates are the subject of the proceeding, any person whose petition to intervene in the proceeding has been granted pursuant to section 2661.3(g), and the Department.

(g) "Pleading" means any petition, notice of hearing, notice of defense, answer, motion, request, response, brief, or other formal document filed with the Administrative Hearing Bureau pursuant to this subchapter. The original of each pleading shall be signed by each party or the party's attorney or representative.

(h) "Proceeding" means any action conducted pursuant to Article 10 of Chapter 9 of Part 2 of Division 1 of the California Insurance Code, entitled "Reduction and Control of Insurance Rates," including a rate proceeding established upon the submission of a petition for hearing pursuant to California Insurance Code section 1861.05 and section 2653.1 of this subchapter.

(i) "Service" means to provide a copy of a pleading to every other party in the proceeding in conformity with California Code of Civil Procedure sections 1011 and 1013. When a party files a pleading, the party shall concurrently serve that pleading on all other parties in the proceeding.

All filed pleadings shall be accompanied by an original declaration of service in conformity with California Code of Civil Procedure sections 1011 and 1013. All served pleadings shall be accompanied by a copy of the declaration of service. An employee of a party may sign a declaration of service.

A specific pleading may be served by facsimile or electronic transmission when authorized by the receiving party.

A sample declaration of service form can be found in section 2623.9.

(j) "Settlement" means an agreement among some or all of the parties to a proceeding on a mutually acceptable outcome to the proceeding.

(k) "Stipulation" means an agreement among some or all of the parties to a proceeding on the resolution of any issue of fact or the applicability of any provision of law material to the proceeding.

(*l*) "Submit" means the act of delivery of a pleading to the Rate Enforcement Bureau.

NOTE: Authority cited: Sections 1861.05 and 1861.055, Insurance Code. *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(c), 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 3 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of second paragraph of subsection (d) (Register 96, No. 5).
3. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5)
4. Amendment of subsections (a), (e), (g) and (i) filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).
5. Amendment of subsection (h) filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

Article 4. Procedural Requirements

§ 2652.1. Form and Size.

Pleadings shall comply with Rule 201(b), (c), and (d) of the California Rules of Court, except that the use of recycled paper is encouraged.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 4 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–8–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.2. Title and Case Number.

(a) Any pleading filed shall show the full name, mailing address, street address if different than the mailing address, and telephone number of the person filing it or that person's attorney or representative, if any, the caption of the proceeding, the case number (if assigned), and the title of the pleading. Not less than a three–inch square of the upper right–hand corner of the first page shall be available for the use of the Department.

(b) Pleadings initiating new proceedings shall leave a space for the case number.

(c) Sample forms can be found in Article 12 of this subchapter.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.3. Verification.

(a) Petitions and Answers, Requests for Findings of Eligibility to Seek Compensation, and Requests for Award, or amendments thereto, shall be verified. Verification may be made by the party's attorney or advocate and shall be made by declaration under penalty of perjury under California law.

(b) Sample verification forms can be found in sections 2623.6, 2623.7, and 2623.8.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.4. Good Faith Requirement.

Any person filing a pleading is thereby certifying that, to the best of the person's knowledge, information, and belief, the pleading is not being presented for any improper purpose, such as to delay, harass, or intimidate. The administrative law judge shall strike any pleading filed for an improper purpose such as to delay, harass, or intimidate. No pleading shall be stricken except on written request of a party, filed no later than ten (10) days after service of the pleading and following notice and an opportunity to be heard. The hearing shall be held no later than ten (10) business days after filing of the request. Any party may file a written response to a request within five (5) business days of filing of the request.

NOTE: Authority cited: Section 1861.055, Insurance Code. *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(c), 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of NOTE (Register 96, No. 5).
3. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5)

§ 2652.5. Place of Filing.

Unless otherwise directed, all pleadings filed pursuant to this subchapter shall be filed with the Administrative Hearing Bureau, 45 Fremont Street, 22nd Floor, San Francisco, CA 94105. However, petitions for hearing shall be submitted to the California Department of Insurance, Rate Enforcement Bureau, 45 Fremont Street, 21st Floor, San Francisco, CA 94105, and shall not be filed with the Administrative Hearing Bureau.

(b) Filing and service shall be accomplished by 4:30 p.m. local time on any due date.

NOTE: Authority cited: Section 1861.055, Insurance Code. *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(c), 1861.055, 1861.07, 1861.08 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment of first paragraph filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2652.6. Amendment of Pleadings.

The filing of a pleading does not establish that it complies with all requirements, and its receipt is not a waiver of those requirements. The administrative law judge may, within five (5) business days after filing of a pleading, require amendment of a pleading. Any amendment shall be filed within five (5) business days of service of the order requiring amendment.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055, 1861.08 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.7. Acknowledgments.

Any person who desires an acknowledgment of the filing of a pleading shall so request and shall furnish an extra copy of the letter of transmittal or of the first page of the pleading. A self–addressed envelope with postage fully prepaid shall be provided if the party requests that a conformed copy be returned by mail.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055, 1861.08 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.8. Public Notice of Rate Applications.

A list of all rate change applications proposed within the previous thirty–six (36) months shall be available for public inspection at the public viewing rooms in San Francisco and Los Angeles. A copy of this Public Notice of Insurance Company Rate Application list ("List") shall be mailed weekly without charge to any person who makes a written request therefor with the Rate Filing Bureau, 45 Fremont Street, 23rd Floor, San Francisco, CA 94105. The Commissioner shall annually notify those receiving the list that, in order to continue to receive the list, they must provide written confirmation to the Rate Filing Bureau, within thirty (30) days of the date of the notice, that they wish to continue to receive the list.

NOTE: Authority cited: Section 1861.06, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(c), 1861.055, 1861.06, 1861.07 and 12973.7, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.9. Public Inspection.

In addition to the information set forth in California Insurance Code section 1861.07, all pleadings filed pursuant to this subchapter shall be available for public inspection at the Department's public viewing rooms in Los Angeles and San Francisco,

NOTE: Authority cited: Section 1861.07, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.07, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2652.10. Contact With Department Staff.

Once a Notice of Hearing has been filed regarding an application, neither the applicant nor any intervenor shall discuss the application, or any

issues related to the application, with the Commissioner or any employee of the Department of Insurance other than employees of the Rate Enforcement Bureau, employees of the Administrative Law Bureau other than any administrative law judge, and/or the Public Advisor.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

Article 5. Petition for Hearing

§ 2653.1. Petition for Hearing.

(a) Any person, whether as an individual, representative of an organization, or on behalf of the general public, may request a hearing by submitting a petition for hearing ("petition"), which is a pleading containing:

(1) An objection to the granting, in whole or in part, of the rate requested in an application, or other request to initiate a proceeding and the basis therefor; and

(2) A request for a public hearing; and

(3) An offer of the evidence which the person requesting the hearing would present or elicit at the public hearing.

(b) A petition for hearing shall state, in plain language, the facts constituting grounds for the request for hearing, and the relief sought. A petition submitted in response to an application shall list the line(s) of insurance for which the rate change is sought, the percentage rate change for each line, and the Department's Rate Filing Bureau application number(s).

(c) When a petition for hearing is submitted, the petitioner shall serve a copy on each insurer named in the petition.

(d) All petitions for hearing shall be available for public inspection at the Department's public viewing rooms in Los Angeles and San Francisco.

(e) A sample petition for hearing form can be found in section 2660.2.

NOTE: Authority cited: Sections 1861.05(c) and 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1858, 1861.05(c), 1861.055 and 1861.10, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 5 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2653.2. Time Limitations.

Except for a petition submitted in response to an application, no petition for hearing regarding any rate shall be considered by the Commissioner if that rate has been approved by the Commissioner after a hearing, and the effective date of approval is within the preceding 12 months, unless the petition sets forth relevant circumstances which have changed since that approval. Relevant changed circumstances include, but are not limited to, changes in the law such as that created by *Moradi–Shalal v. Fireman's Fund Insurance Companies*, 46 Cal.3d 287 (1988) and *Garvey v. State Farm Fire & Casualty Company*, 48 Cal.3d 395 (1989) which can be expected to have a substantial effect on insurer payouts, or any other change which would result in an approved rate being excessive, inadequate, unfairly discriminatory, or otherwise in violation of Chapter 9 of Part 2 of Division 1 of the California Insurance Code.

NOTE: Authority cited: Sections 1861.05(a) and (c), 1861.055 and 1861.10, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05, 1861.055, 1861.08 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2653.3. Response to Petition.

The Department's Rate Enforcement Bureau may, within three (3) days of submission of the petition for hearing, provide the Commissioner with a response to the petition for hearing. A copy of any response shall be served on the person submitting the petition for hearing and any insurer named in the petition, but shall not be filed with the Administrative Law Bureau.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2653.4. Answer to Petition.

(a) An insurer served with a petition for hearing may submit and serve an answer to the petition. If the insurer chooses to answer the petition, it must do so within five (5) business days of the date of service of the petition.

(b) The answer shall admit or deny each material allegation in the petition and raise any defenses or justifications. It shall also set forth any defects in the petition which require amendment or clarification. Answers shall comply with the requirements of sections 2652.1–2652.3 of this subchapter.

(c) Answers shall not be filed with the Administrative Law Bureau.

(d) A sample answer form can be found in section 2660.3.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11506, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2653.5. Granting of Hearing.

The Commissioner shall determine whether to grant or deny a hearing under Insurance Code section 1861.05(c)(1) based upon the content of the petition, the application, and any officially noticeable information.

The petition for hearing, any response, any answer, and the Commissioner's determination whether to grant or deny a hearing shall be part of the record in the proceeding and, if the Commissioner grants a hearing, shall be filed by the Rate Enforcement Bureau with the Administrative Law Bureau.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

Article 6. Administrative Law Judges

§ 2654.1. Authority.

(a) To the extent not otherwise specified by law or regulation, the administrative law judge shall: control the course of proceedings; grant or deny requests for continuances; administer oaths; issue subpoenas; rule on motions to compel discovery; receive evidence; upon notice, hold appropriate conferences before or during hearings; rule upon all objections or motions which do not involve final determination of proceedings; receive offers of proof; hear argument; recommend to the Commissioner approval or disapproval of proposed stipulations and settlements; and, except as set forth in section 2657.1, fix the time and place for the filing of briefs.

(b) The administrative law judge shall eliminate unnecessary delay in the progress and ultimate resolution of the proceeding, assume and maintain control over the pace of the proceeding, actively manage the proceeding from commencement to disposition, and compel all parties to prepare and resolve all issues without delay. The administrative law judge shall discourage continuances, only granting continuances for good cause shown. Good cause includes circumstances such as serious illness of a participant in the proceeding, death in the family of a participant in the proceeding, or jury duty obligations of a participant in the proceeding.

(c) The administrative law judge shall, when appropriate, consolidate cases and/or require coordination and cooperation among multiple intervenors. The administrative law judge may limit the number of witnesses, the time for testimony upon a particular issue, and use other procedures in order to avoid unnecessarily cumulative evidence or the undue consumption of time. The administrative law judge shall take any other action necessary or appropriate to the discharge of his or her duties, consistent with the statutory or other authority under which the Commissioner functions.

(d) The presiding administrative law judge, who directs the Administrative Law Bureau and all other administrative law judges, shall exercise all authority set forth in this section until a proceeding is assigned to an administrative law judge.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08(a), Insurance Code, Sections 11512 and 11513, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 6 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2654.2. Decisions Regarding Certification of Questions to the Commissioner.

Certification requests made pursuant to Title 10, California Code of Regulations, section 2646.2 shall be granted or declined within fifteen (15) days of the request for certification. The Commissioner's denial of a certification request shall be without prejudice to any party or the right of any party to raise the question again in the same or future proceedings.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

Article 7. Evidence

§ 2655.1. Discovery.

(a) The Department may include a discovery request with a notice of hearing. If it does so within twenty (20) days following the service of a discovery request, the insurer shall deliver to the Department and any interveners copies of all items requested that meet the standards of discoverable items in Government Code section 11507.6, liberally construed. The insurer and any intervener may also request discovery concurrently with the filing and service of each party's initial pleading. The written response to any discovery request other than a discovery request served with the Notice of Hearing shall be served on the requesting party within ten (10) days of service of the discovery request. Upon mutual agreement of all parties and interveners: 1) written documents may be converted into another mutually agreeable format, such as electronic or magnetic, and made readily available, or 2) a depository of original items may be used in place of delivery of copies, but the depository shall be open beyond regular business hours upon request of a party or intervener. The parties shall have an ongoing duty to produce additional items pursuant to whichever method is agreed upon as new items become relevant.

(b) A response shall also contain a list specifically identifying the items not produced that are responsive to the request, in a form that can be read in connection with the specifically stated objections for each requested item that is not made available. The withholding party shall specify precisely why the stated objection applies to the specific item withheld.

When a party withholds information otherwise discoverable by claiming it is privileged, that party shall make the claim expressly and shall describe the nature of the documents, communications, or things not produced or disclosed in a manner that, without revealing information itself privileged or protected, will enable other parties to assess the applicability of the specifically asserted privilege or protection. Simultaneously, the withholding party shall also draft and provide a confidentiality agreement to the other parties and the administrative law judge if a confidentiality agreement can protect the interest in nondisclosure.

Nothing in this section shall require any party to disclose information contained in a document which is privileged from disclosure by law or otherwise made legally confidential or protected as an attorney's work product.

(c) Any party claiming that a request for discovery has not been complied with shall, within five (5) business days of receipt of the responses referred to in (b) above, meet and confer with the party from whom discovery is sought to attempt to resolve the discovery dispute.

(d) Any party claiming that a request for discovery has not been complied with following the meet and confer session shall, within five (5) business days of the meet and confer session, file and serve a motion to compel discovery accompanied by a copy of the original discovery request and response thereto. The motion to compel discovery shall contain a statement specifying why the requested information is sought, and include facts showing a reasonable and good faith attempt at an informal resolution of each issue presented by the motion. The party from whom

discovery is sought shall file and serve any additional response within five (5) business days of service of the motion. The administrative law judge shall set a hearing on the motion for a time within ten (10) business days after filing of the response. At or before the commencement of the hearing, the administrative law judge shall inform the parties of his or her tentative ruling on the motion. The administrative law judge shall issue a decision on the motion to compel discovery within five (5) business days of the date of the hearing on the motion to compel discovery.

(e) Nothing in this section shall prohibit the administrative law judge, in appropriate circumstances, from ordering in camera inspection of documents or entering a protective order for documents not subject to California Insurance Code section 1861.07. Nothing in this section shall prohibit the administrative law judge from extending the time frame for discovery for good cause shown.

(f) Any party who disagrees with a decision of the administrative law judge on a motion to compel discovery and desires review of the decision may, within five (5) business days of the date of service of the decision regarding discovery, request the Commissioner to review the discovery decision of the administrative law judge. The request shall be provided to the San Francisco office of the Commissioner, 45 Fremont Street, 23rd Floor, San Francisco, CA 94105 and served on all parties and the administrative law judge. The request shall specify why the party believes the decision of the administrative law judge is in error. The Commissioner shall review the decision of the administrative law judge, as well as all pleadings filed in connection with the motion to compel discovery and the transcript of the hearing on the motion to compel discovery, and issue a decision within fifteen (15) days of receipt of the request to review. The hearing schedule shall be stayed during the time of the Commissioner's review.

(g) All discovery requests, responses, and/or motions to compel discovery shall be made in good faith, and the administrative law judge shall strike any discovery request, response, and/or motion to compel intended only to delay, harass, or intimidate. No discovery request or response shall be stricken except on written request of a party, filed no later than five (5) business days after service of the discovery request, response, or motion to compel discovery and following notice and an opportunity to be heard. The hearing shall be held no later than ten (10) business days after filing of the request. Any party may file a written response to a request within five (5) business days of filing of the request.

(h) Unless a party files a motion to compel discovery, discovery requests, responses thereto, and lists of items not produced shall not be filed with the Administrative Hearing Bureau.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08(e), Insurance Code, Sections 11507.6, 11507.7 and 11511, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 7 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of subsection (e) (Register 96, No. 5).
3. Certificate of Compliance as to 8–18–95 order; including amendment of subsection (e), transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5)
4. Amendment of section and NOTE filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2655.2. Documentary Evidence.

Documents offered in evidence shall not contain significant amounts of irrelevant or immaterial information. A party offering a document in excess of ten (10) pages shall designate specifically the relevant and material portions, and shall provide a copy of the entire document to every other party prior to the offer in evidence. The other parties shall be provided five (5) business days to examine the document from the date of receipt of the document, and to offer in evidence other relevant and material portions of the document. If admission of the entire document would unnecessarily encumber the record, the document shall not be received in evidence, but the relevant and material portions shall be received as an exhibit or exhibits of the parties.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11513, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2655.3. Exhibits.

Exhibits shall be legible and whenever practicable either prepared on paper not exceeding 8–1/2 inches wide and 11 inches long, or bound or folded to that approximate size. Exhibits may be created during the hearing, but shall be recreated for the record on paper not exceeding 8–1/2 inches wide and 11 inches long. Wherever practicable, the sheets of each exhibit shall be numbered. Copies of exhibits shall be clear and legible.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11513, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2655.4. Copies to All Parties.

Except for exhibits created during the course of the hearing, when exhibits are marked for identification, the original and one (1) copy shall be furnished to the administrative law judge and one (1) copy furnished to each party or attorney, the witness, and two (2) copies to the court reporter. For exhibits created during the course of the hearing: Within five (5) days of the date of their completion, two (2) copies shall be furnished to the administrative law judge and one (1) copy shall be furnished to each party or attorney and two (2) copies to the court reporter. Four (4) additional copies of each exhibit shall be filed with the Administrative Law Bureau Calendar Clerk within ten (10) days of the date the exhibit is marked for identification or completed during the proceeding.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2655.5. Additional Evidence.

(a) The administrative law judge may require the production of further evidence on any issue until the record is closed. If the administrative law judge determines that specific documentary evidence is necessary as a part of the record, the administrative law judge shall set a deadline for filing, reserving exhibit numbers therefor. Copies of all documents produced shall be served on all parties.

(b) If the administrative law judge requires the production of further evidence, that evidence shall be provided no later than ten (10) days from the date the administrative law judge notifies the party from whom the evidence is sought that additional evidence is required.

(c) Any objections to admitting the evidence produced upon the administrative law judge's order shall be filed no later than five (5) days after the evidence is served.

(d) Unless ordered by the administrative law judge, evidence other than matters that can be officially noticed shall not be provided after the close of the evidentiary hearing.

(e) In no event shall the record close more than fifteen (15) days after oral argument.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2655.6. Prepared Testimony.

(a) Prepared direct testimony, in narrative statement or question and answer format, of each direct witness expected to be called to testify by the applicant in a proceeding, shall be filed and served on all parties at least forty (40) business days before the first day of the evidentiary hearing. Prepared direct testimony, in narrative statement or question and answer format, of each direct witness expected to be called to testify in a proceeding by any party other than the applicant, shall be filed and served on all parties no later than twenty (20) business days after service of the applicant's prepared direct testimony. Prepared direct testimony shall be signed under penalty of perjury under the laws of the state of California. Expert witness testimony shall be accompanied by the witnesses' curriculum vitae and list of authored or co–authored publications. Additionally, any documents reviewed by the expert for purposes of testifying in the specific case that were not previously provided to the other parties shall be produced with the testimony.

(b) Within five (5) business days of service of any prepared direct testimony, any party may file a motion to strike all or part of the testimony. The motion shall state the specific page(s) and line(s) to which the party is objecting, and the specific legal authority for the objection. Within five (5) business days of service of a motion to strike, the party filing the prepared direct testimony may respond to the motion to strike. A hearing on any motion to strike shall be held within five (5) business days of service of any response to the motion to strike. At or before the commencement of the hearing on the motion to strike, the administrative law judge shall inform the parties of his or her tentative ruling on the motion. The administrative law judge shall rule on the motion to strike no later than two (2) business days after the hearing on the motion to strike. Any testimony not objected to and any testimony not stricken, together with exhibits referenced in that testimony, shall be deemed admitted.

(c) If rebuttal prepared testimony is allowed, motions to strike may be made orally and ruled upon immediately in order to expedite the proceeding.

(d) At the evidentiary hearing, the person whose prepared testimony is being offered shall be available for cross–examination by all parties.

(e) Prepared testimony of more than twenty (20) pages shall contain a subject index.

(f) This section is not intended to replace the provisions of Government Code section 11514.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code; Sections 11507.6, 11511 and 11513, Government Code; Section 801(b), Evidence Code; *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment of section and NOTE filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2655.7. Order of Proof.

In addition to its burden of proof, the applicant shall have the burden of presenting its evidence and witnesses first.

NOTE: Authority cited: Sections 1861.05 and 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05, 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2655.8. Additional Direct Testimony.

(a) Prior to his or her cross–examination, any witness may provide additional direct testimony responding to testimony elicited of any other witness. Any additional direct testimony which is likely to take more than one hour of hearing time to present shall meet all requirements applicable to direct testimony, shall be in the format specified in section 2655.6, and shall be filed and served on all parties at least two (2) business days before the witness is called to testify.

(b) If updated data underlying the application becomes available during the course of the hearing, the applicant shall provide the updated data as additional direct testimony as soon as practical after the updated data becomes available. This additional direct testimony shall meet all requirements applicable to direct testimony, shall be in the format specified in section 2655.6, and shall be filed and served on all parties at least two (2) business days before the witness is called to testify on the updated data.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2655.9. Rebuttal Testimony.

At the conclusion of the direct presentations of all parties, the parties may file written rebuttal testimony. The rebuttal testimony shall meet all requirements applicable to direct testimony, shall be in the format specified in section 2655.6 and shall be filed and served on all parties at least two (2) business days before the rebuttal witness is called to testify. The rebuttal testimony shall only respond to testimony of another party or witness.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insur-

ance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2655.10. Official Notice.

No party shall file a Request for Official Notice after it files its opening brief as authorized by section 2657.1(d). Objections to official notice requests shall be filed no later than with reply briefs; any written refutation shall accompany the objection. If the administrative law judge determines, without a request, to take official notice of a matter, notice shall be given to the parties, who shall have five (5) days to offer objections or written refutation.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11515, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

Article 8. Stipulations and Settlements

§ 2656.1. Proposal of Stipulations or Settlements.

(a) Parties may stipulate to the resolution of an issue of fact or the applicability of a provision of law material to a proceeding, or may agree to settlement on a mutually acceptable outcome to a proceeding, with or without resolving material issues.

(b) Notice of the stipulation and a copy of the stipulation shall be served on any intervenor at the time of filing. However, no party to a proceeding pending before the Commissioner shall compensate or agree to compensate an intervenor, and no intervenor shall receive or agree to receive compensation from any party in connection with a proceeding pending before the Commissioner, other than a compensation award approved by the Commissioner in accordance with Article 14 of Subchapter 4.9. No agreement concerning the merits of any matter pending before the Commissioner may be conditioned upon the payment of compensation to an intervenor.

(c) Stipulations and settlements shall be filed with the administrative law judge for proposed acceptance or rejection. When a stipulation or settlement is filed with the administrative law judge, it shall also be served on all parties. If a stipulation dispositive of the case or a settlement is proposed prior to the taking of any testimony, the parties supporting the stipulation or settlement shall file and serve supporting declarations indicating the reasons that the settlement or stipulation is fundamentally fair, adequate, reasonable and in the interests of justice. The administrative law judge shall reject any stipulation or settlement which includes an agreement regarding intervenor fees.

(d) Stipulations shall be limited to the issues in the proceeding and shall have no precedential value for future proceedings.

(e) A settlement or stipulation involving an agreed–upon rate change shall list, for each applicable subline and overall, the California written premium for the prior calendar year, the rate change proposed in the rate application, and the agreed–upon rate change.

(f) Any party may discuss stipulations or settlement with any other party without involving all parties.

(g) Any party objecting to a proposed settlement or stipulation may, within five (5) days of service of the proposed settlement or stipulation, file a written objection and may request a hearing before the administrative law judge on the proposed settlement or stipulation. When a hearing is requested, the administrative law judge shall hold a hearing on the objections within ten (10) business days of the filing of the request.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11511.5, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 8 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2656.2. Rejection of Stipulation or Settlement.

(a) The administrative law judge shall reject a proposed stipulation or settlement whenever, in his or her judgment, the stipulation or settlement is not in the public interest and is not, taken as a whole, fundamentally fair, adequate, and reasonable. Upon rejection, the administrative law judge may propose acceptable alternative terms to the parties and allow the parties reasonable time to consider those terms. Any party may, in writing and within three (3) days of the administrative law judge's rejection of a proposed stipulation or settlement, request the Commissioner's review of that rejection. A copy of any request shall be filed with the Administrative Hearing Bureau.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2656.3. Adoption of Stipulation or Settlement.

(a) Adoption of a stipulation or settlement by the administrative law judge alone does not constitute approval of, or precedent regarding, any principle or issue in the proceeding or in any future proceeding.

(b) The terms of a stipulation or settlement adopted by the administrative law judge shall be included in any proposed decision provided to the Commissioner.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11511.5, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2656.4. Inadmissibility.

(a) Discussions, admissions, concessions or offers to stipulate or settle, whether oral or written, made during any negotiation or settlement conference are confidential and inadmissible for any purpose in any proceeding.

(b) If a stipulation or settlement is not adopted by the administrative law judge, no evidence regarding the terms of the proposed stipulation or settlement shall be admissible for any purpose in any proceeding.

(c) The Commissioner's approval of an insurer's application or amended application without a hearing and without specific findings of fact and determinations of issues shall not constitute approval of or precedent regarding any principle or issue in any other proceeding.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Sections 11511.5 and 11513, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994); and *RLI Insurance Co. Group v. Superior Court*, 51 Cal.App.4th 415 (1996).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment of subsection (c) and amendment of NOTE filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

Article 9. Post–Hearing Briefs and Oral Arguments

§ 2657.1. Post–Hearing Briefs.

(a) Except as otherwise specified in this subchapter, the administrative law judge shall fix all dates for the filing and service of post–hearing briefs.

(b) Citations to the transcript of a proceeding shall indicate the transcript page number.

(c) All briefs in excess of ten (10) pages shall contain a table of contents and a table of authorities.

(d) All parties shall file concurrent opening briefs thirty (30) days after the close of the evidentiary hearing and all parties shall file concurrent reply briefs fifteen (15) days after filing of the opening briefs.

(e) Exclusive of the table of contents and table of authorities, opening briefs shall not exceed 50 pages, and reply briefs shall not exceed 25 pages. Upon written motion and for good cause shown, these page limits may be increased in cases which present novel or extremely technical issues, and they may be decreased in cases that do not present such issues. However, briefs exceeding the page limits set forth in this section are to be discouraged.

(f) Briefs, and exhibits to briefs, shall not refer to, or introduce, any evidence whatsoever which was not admitted at the evidentiary hearing or which is not officially noticeable.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11511.5, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 9 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5)

§ 2657.2. Oral Argument.

When, after the close of the evidentiary hearing and the filing of post–hearing briefs, the administrative law judge believes that the complexity or importance of the issues so warrant, the administrative law judge may require or permit the presentation of oral argument within 25 days after the filing of reply briefs. At least ten (10) days prior to the date set for oral argument, the administrative law judge shall serve a list of questions and/or issues that shall be addressed at the oral argument.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order; including amendment of subsection (f), transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

Article 10. Submission of Proceeding

§ 2658.1. Submission of Proceeding.

A proceeding shall stand submitted when the record closes.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11517, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 10 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

Article 11. Petitions for Reconsideration

§ 2659.1. Petitions for Reconsideration.

Petitions for reconsideration of the Commissioner's final decision shall be provided, within the time set forth in Government Code section 11521, to the Commissioner, filed with the Administrative Hearing Bureau and served on all parties.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11521, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 11 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).
3. Amendment of section heading and section filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2659.2. Contents.

Petitions for reconsideration shall be based solely upon, and shall set forth specifically, the grounds upon which the decision of the Commissioner allegedly is contrary to law or is erroneous. A petition for reconsideration shall not refer to, or introduce, any evidence whatsoever which was not presented at the evidentiary hearing. Any such evidence nonetheless provided shall be accorded no weight. The purpose of a petition for reconsideration is to alert the Commissioner to an error so that the error may be corrected expeditiously. Copies of documents received in evidence or already part of the record shall not be attached as exhibits.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32

Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11521, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2659.3. Response.

A response to a petition for reconsideration is not necessary. However, if a response is provided, it must be provided within the time set forth in Government Code section 11521, and filed and served in the same manner as the petition for reconsideration.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11521, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2659.4. Hearing on Petition.

The Commissioner may, but is not required to, hold a hearing or accept argument on the petition for reconsideration.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055 and 1861.08, Insurance Code, Section 11521, Government Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

Article 11.5. Judicial Review

§ 2660. Served on the Administrative Hearing Bureau.

Any party petitioning for trial court or appellate review of a Commissioner's decision arising from a rate hearing shall serve on the Administrative Hearing Bureau a copy of the petition and the final decision from each reviewing court.

NOTE: Authority cited: Sections 1861.055, 1861.09 and 1858.6, Insurance Code; *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989); and *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1858.6, 1861.055 and 1861.09, Insurance Code; *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989); and *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 11.5 (section 2660) and section filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

Article 12. Sample Forms

§ 2660.1. Forms.

The following forms are merely illustrative as to general format. The content of a particular pleading may vary, depending upon the subject matter and applicable rules.

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(b), (c), 1861.055, 1861.08 and 1861.10(a), (b), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New article 12 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2660.2. Petition for Hearing.

Name
Address
Telephone Number of Petitioner or Advocate

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of	)	Case No.
	)	
____ Insurance Company,	)	PETITION FOR HEARING
	)	
Applicant.	)	
	)	

The petition of (exact legal name, mailing address and telephone number of petitioner) respectfully shows:

I

(Here, and in succeeding numbered paragraphs, set forth fully and clearly the facts constituting the grounds for the petition. Additionally, list the line(s) of insurance for which the rate change is sought, the percentage rate change for each line, and the Department's Rate Filing Bureau application number(s).)

II

Petitioner hereby requests the Insurance Commissioner to schedule a public hearing at which time _____ Insurance Company will be directed to appear, respond to the issues raised in this petition and _____.

III

At that hearing, petitioner will present or elicit evidence that _____.

IV

This petition does not involve a rate which has been specifically approved by the Insurance Commissioner within the preceding _____ months (or relevant changed circumstances are _____).

V

If the Insurance Commissioner grants a hearing on petitioner's request, petitioner will seek to intervene in that hearing pursuant to Insurance Code section 1861.10.

WHEREFORE _____.

DATED:

_____
Signature

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.05(c), 1861.055, 1861.08 and 1861.10(a), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

§ 2660.3. Answer.

Name
Address
Telephone Number of Insurer or Attorney

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of	)	Case No.
	)	
____ Insurance Company,	)	ANSWER TO PETITION
	)	FOR HEARING
Applicant.	)	
	)	

_____ Insurance Company alleges:

I

Applicant admits the allegations contained in paragraphs _____ of the petition for hearing.

II

Applicant denies the allegations contained in paragraphs _____ of the petition for hearing.

III

The allegations contained in paragraphs _____ of the petition for hearing are justified because _____.

IV

Applicant raises the following affirmative defenses _____.

V

Defects in the petition requiring amendment or clarification are _____.

WHEREFORE, Applicant requests _____.

DATED:

_____
Signature

NOTE: Authority cited: Section 1861.055, Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994). Reference: Sections 1861.055, 1861.08 and 1861.05(c), Insurance Code, *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal.Rptr.2d 807, 847 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–18–95 order transmitted to OAL 12–18–95 and filed 2–1–96 (Register 96, No. 5).

Article 13. Intervention

§ 2661.1. Definitions.

The following definitions shall apply to Articles 13 and 14 of this subchapter.

(a) "Advocacy Fees" means costs, incurred or billed, by a party for the services of an advocate in the proceeding. An advocate need not be an attorney. Advocacy fees shall not exceed market rates as defined in this section.

(b) "Compensation" means payment for all or part of advocacy fees, witness fees, and other expenses of participation and intervention in any rate hearing or proceeding other than a rate hearing.

(c) "Market Rate" means, with respect to advocacy and witness fees, the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas at the time of the Commissioner's decision awarding compensation for attorney advocates, non–attorney advocates, or experts with similar experience, skill and ability. Billing rates shall not exceed the market rate.

(d) "Other Expenses" means reasonable, actual out–of–pocket costs of an intervenor or petitioner. Out–of–pocket costs include but are not limited to expenses such as travel costs, transcript charges, postage charges, overnight delivery charges, telephone charges and copying expenses. Out–of–pocket costs also includes the costs incurred in preparing a request or amended request for award, defined in sections 2662.3 and 2662.4. The intervenor or petitioner has the burden of substantiating any costs incurred, including providing supporting documentation as requested by the Public Advisor.

(e) "Proceeding" includes those proceedings set forth in Insurance Code Section 1861.10(a).

(f) "Proceeding Other Than a Rate Proceeding" means any proceeding, including those described in subdivision (e) above, conducted pursuant to Chapter 9 of Part 2 of Division 1 of the Insurance Code which is not a rate proceeding as defined in this section.

(g) "Public Advisor" means that official of the Department of Insurance who monitors and assists participation by members of the public in the Department of Insurance's proceedings. The Public Advisor shall not represent any member of the public and shall not advocate any substantive position on behalf of the public on any issues before the Commissioner.

(h) "Rate Proceeding" means any proceeding conducted pursuant to Insurance Code Sections 1861.01 and 1861.05. For purposes of section 1861.05, a "rate proceeding" is established upon the submission of a petition for hearing in accordance with section 2653.1 of this subchapter, or if no petition for hearing is filed, upon notice of hearing.

(i) "Rate Hearing" means a hearing noticed by the Commissioner on his own motion or in response to a petition for hearing pursuant to Insurance Code section 1861.05, which is conducted pursuant to the applicable procedural requirements of Insurance Code section 1861.08, and subchapters 4.8. and 4.9 of this chapter.

(j) "Represents the Interests of Consumers" means that the intervenor represents the interests of individual insurance consumer[s], or the intervenor is a group organized for the purpose of consumer protection as demonstrated by, but is not limited to, a history of representing consumers in administrative, legislative or judicial proceedings.

A party which represents, in whole or in part, any entity regulated by the Commissioner shall not be eligible for compensation. However, nothing in this subsection shall be construed to prohibit any person from intervening or participating if that person is not seeking compensation.

(k) "Substantial Contribution" means that the intervenor substantially contributed, as a whole, to a decision, order, regulation, or other action of the Commissioner by presenting relevant issues, evidence, or arguments which were separate and distinct from those emphasized by the Department of Insurance staff or any other party, such that the intervenor's participation resulted in more relevant, credible, and non–frivolous information being available for the Commissioner to make his or her decision than would have been available to a Commissioner had the intervenor not participated. A substantial contribution may be demonstrated without regard to whether a petition for hearing is granted or denied.

(*l*) "Witness Fees" means recorded or billed costs for a witness, together with associated expenses. Costs and expenses for a witness shall not exceed market rate as defined in this section.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. Renumbering and amendment of former section 2616.1 to new section 2661.1 filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. Renumbering and amendment of former section 2616.1 to new section 2661.1 refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. Renumbering and amendment of former section 2616.1 to new section 2661.1 filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order, including amendments to subsections (c), (d), (e) and (i), transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).
6. Amendment of subsections (d), (f) and (h), new subsection (i), subsection relettering and amendment of newly designated subsection (k) filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2661.2. Intervention of Right.

Any person shall be permitted to intervene in any proceeding on any rate application or in any proceeding subject to Chapter 9 of Part 2 of Division 1 of the California Insurance Code if the issues to be raised by the intervenor or participant are relevant to the issues of the proceeding. A person desiring to intervene or participate in any proceeding shall use the forms set forth in sections 2623.1 through 2623.9 of this subchapter, which shall be verified.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. New section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order, including amendment of section, transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2661.3. Procedure for Intervention in a Rate or Class Plan Proceeding.

(a) A person desiring to intervene and become a party to a rate class plan proceeding shall file a petition to intervene which shall be drafted in compliance with sections 2652.1–2652.4 of this subchapter. A person who petitions for a hearing may combine a petition to intervene with a petition for hearing in one pleading.

(b) The Petition shall cite the law authorizing the proposed intervention and shall contain the petitioner's interest in the proceeding, the specific issues to be raised and the positions to be taken on each issue to the extent then known, and the name, address, and telephone number of the petitioner. The verified petition shall include a statement that the intervenor or advocate will be able to attend and participate in the proceeding without delaying the proceeding or any other proceedings before the Commissioner.

(c) The Petition shall also state whether the petitioner intends to seek compensation in the proceeding, and, if so, contain an itemized estimated budget for the participation in the proceeding, which shall set forth the following:

(1) separate listings of the rates for each attorney advocate or non-attorney advocate, including:

(A) the names of each attorney advocate or non-attorney advocate,

(B) the rates to be claimed for each attorney advocate or non-attorney advocate,

(C) a description of the work to be performed by each attorney advocate or non-attorney advocate, an estimate of the time to be spent to perform that work and the rates, fees and costs associated with that work; and,

(2) separate listings of the rates for each witness, including:

(A) the names of each witness and their areas of expertise,

(B) the rates to be claimed for each witness,

(C) a description of the work to be performed by each witness, an estimate of the time to be spent to perform that work and the rates, fees and costs associated with that work;

Rates contained in the estimated budget shall not exceed market rates. Submission of the budget shall not guarantee the payment of the dollar amounts set forth in the budget. The lack of objection to any item in the budget shall not imply approval of the budget.

(d) An amended budget shall be submitted as soon as possible when the intervenor learns that the total estimated budget amount increases by $10,000 or more.

(e) A Petition to Intervene in a rate or class plan proceeding may be submitted to the Rate Enforcement Bureau concurrently with a petition for hearing submitted pursuant to section 2653.1 of this subchapter or filed with the Administrative Hearing Bureau after a hearing is granted, and shall be considered an "additional pleading" within the meaning of Government Code Section 11507.6. A copy of the Petition to Intervene shall be served on the Public Advisor and all of the parties to the proceeding. A Petition to Participate shall be submitted to the contact person for the proceeding, and served on the Public Advisor.

(f) Within five (5) days after filing of the Petition to Intervene, any other party may file a response to the Petition to Intervene. Any party claiming that the petitioner does not represent the interests of consumers shall so state in the response, which shall include any supporting documentation. The petitioner may reply to any allegation in the response and may reply to the allegation that it does not represent the interests of consumers within three (3) days of filing of the response.

(g) If a person who files a petition for a hearing and a Petition to Intervene meets the requirements of this section, represents the interests of consumers pursuant to Insurance Code section 1861.10(b) and is otherwise eligible to seek compensation in proceedings before the Department pursuant to section 2662.2 of this subchapter, that person's Petition to Intervene shall be granted within fifteen (15) days of its submission. If a petition for a hearing has already been granted, the administrative law judge shall rule on any Petition to Intervene subsequently filed by any person within 20 days of its filing with the Administrative Hearing Bureau.

(h) No person whose petition has been granted shall be permitted to reopen matters decided before the petition is granted without a showing of good cause.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. Renumbering and amendment of former section 2617.3 to new section 2661.3 filed 8-18-95 as an emergency; operative 8-18-95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12-16-95 or emergency language will be repealed by operation of law on the following day.
2. Renumbering and amendment of former section 2617.3 to new section 2661.3 refiled 12-19-95 as an emergency; operative 12-19-95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4-17-96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12-19-95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12-19-95 order filed 5-30-96 (Register 96, No. 22).
4. New section filed 5-30-96 as an emergency; operative 5-30-96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9-27-96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5-30-96 order, including amendment to subsections (b), (f) and (g), transmitted to OAL 9-26-96 and filed 11-5-96 (Register 96, No. 45).
6. Amendment of subsections (e) and (g) filed 10-16-2002; operative 11-15-2002 (Register 2002, No. 42).
7. Amendment of section heading and subsections (a), (e) and (h)-(g) filed 12-29-2006; operative 1-28-2007 (Register 2006, No. 52).

§ 2661.4. Procedure for Participation in a Proceeding Other Than a Rate Hearing.

(a) A person desiring to participate in a proceeding other than a rate hearing shall file a petition to participate which shall be drafted in compliance with sections 2652.1-2652.4 and 2661.3(b) through (e) of this subchapter. The petition to participate shall be provided to the contact person for the proceeding.

(b) A ruling on a Petition to Participate shall be made within 15 days of its submission to the contact person for the proceeding.

(c) No person whose petition has been granted shall be permitted to reopen matters decided before the petition is granted without a showing of good cause.

(d) Nothing in this section shall be construed to prohibit any person from providing relevant comments in a proceeding other than a rate hearing if that person is not seeking compensation.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8-18-95 as an emergency; operative 8-18-95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12-16-95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12-19-95 as an emergency; operative 12-19-95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4-17-96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12-19-95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12-19-95 order filed 5-30-96 (Register 96, No. 22).
4. New section filed 5-30-96 as an emergency; operative 5-30-96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9-27-96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5-30-96 order transmitted to OAL 9-26-96 and filed 11-5-96 (Register 96, No. 45).

Article 14. Intervenor's and Participant's Fees and Expenses

§ 2662.1. Purpose.

The purpose of this Article is to establish procedures for awarding advocacy fees, witness fees and other expenses to petitioners, intervenors and participants in proceedings, including proceedings other than rate

proceedings, before the Insurance Commissioner in accordance with Section 1861.10(b) of the Insurance Code. The definitions set forth in section 2666.1 apply to Article 14 of this subchapter.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New article 14 and section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. New article 14 and section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. New article 14 and section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order, including amendment of article heading and section, transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).
6. Amendment filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2662.2. Request for Finding of Eligibility; Time; Contents; Effective for Two Years.

(a) A person or group representing the interests of consumers may provide to the Public Advisor a request for finding of eligibility to seek compensation. The request shall be verified and may be verified by the intervenor's or participant's attorney and shall be submitted, at any time, in conjunction with an ongoing proceeding in which the individual or organization seeks to intervene. The request shall comply with sections 2652.1–2652.4 of this subchapter and shall include:

(1) a showing by the intervenor or participant that it represents the interests of consumers, including a description of the previous work of the intervenor or participant; and,

(2) in the case of groups representing the interests of consumers, the request shall include the following as exhibits:

(A) a copy of the group's articles of incorporation, by–laws, or (for groups not organized as corporations) other organizational documents,

(B) if the group has members, the approximate number of current members,

(C) composition of the group's current Board of Directors — including the name and business address of each director and/or the name and business address of the principals of the group if it is not a corporation,

(D) newsletter circulation, if any, along with a representative sample of newsletters and/or any other publications issued by the intervenor in California during the previous twelve (12) months,

(E) any annual or year–end report for the prior year,

(F) a statement as to whether or not the group has been granted non–profit status under Internal Revenue Code Section 501(c), and

(G) In order to allow a determination whether the group actually does represent the interests of consumers, a listing, by general category, of the group's funding sources for the prior twenty–four (24) months and the approximate total percentage of the group's annual budget from each funding category. Each foundation, corporate, business, or government grant shall be separately listed by name of foundation, corporation, business, or government agency and amount of grant. For each individual who contributed at least five percent of the group's annual budget, the name of the individual and the total amount of the annual contribution shall be separately listed.

The Public Advisor may require additional information regarding the request at any time, but not more than twice during any one calendar year from a given intervenor or participant.

(b) Within 10 days of receipt of a request for finding of eligibility to seek compensation, the Public Advisor shall review the request for completeness. If the request includes all of the information required by subdivision (a) above, it is complete. If the Public Advisor determines that the request is not complete because it does not include all of the information required by subdivision (a), notice stating the grounds for incompleteness will be given to the person or group who submitted the request within the 10 day period and the request will be rejected.

(c) The Commissioner shall rule on the request for a finding of eligibility to seek compensation in writing not later than 15 days from the receipt of a complete request.

(d) A Finding of Eligibility to Seek Compensation shall be valid in any proceeding in which the intervenor's participation commences within two years of the Finding of Eligibility so long as the intervenor(or participant) still meets the requirements of subdivision (a). A Finding of Eligibility to Seek Compensation in no way ensures compensation.

(e) Nothing in the Finding of Eligibility shall prohibit or limit any person or group from making any presentation or advocating any position which is otherwise admissible.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; Sections 446 and 2015, Code of Civil Procedure; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. New section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order, including amendment of section, transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2662.3. Request for Award.

(a) A petitioner, intervenor or participant whose Petition to Intervene or Participate has been granted and who has been found eligible to seek compensation may submit to the Public Advisor, within 30 days after the service of the order, decision, regulation or other action of the Commissioner in the proceeding for which intervention was sought, or at the requesting petitioner's, intervenor's or participant's option, within 30 days after the conclusion of the entire proceeding, a request for an award of compensation. A petitioner, intervenor or participant requesting that any award ordered be made payable to a specific person or entity, other than the petitioner, intervenor or participant, that represented or advocated on behalf of the intervenor or participant during the proceeding shall include verified authorization to that effect in the request.

(b) The request shall be verified and shall be in compliance with sections 2652.1–2652.4 of this subchapter and shall include, at a minimum:

(1) a detailed description of services and expenditures;

(2) legible time and/or billing records, created as soon as possible after the work was performed, which show the date and the exact amount of time spent on each specific task; and

(3) a description of the petitioner's, intervenor's or participant's substantial contribution citing to the record, including, but not limited to, documents such as: declarations by advocates and/or witnesses, written or oral comments of the petitioner or intervenor or its witnesses regarding a rate application provided to the Department, correspondence with the parties, stipulations or settlement agreements regarding the outcome or material issues in the proceeding, and decision or order by the Depart-

ment or Commissioner concerning a petition for hearing or rate or class plan application issued without a formal hearing, transcripts, proposed decisions of the Administrative Law Judge and orders demonstrating that a substantial contribution was made for the purpose of complying with section 2661.1(j). Notwithstanding section 2656.4, any confidential correspondence, documents, or declarations referencing confidential information, including but not limited to confidential settlement communications, may be submitted to the Public Advisor with a request for an award of compensation. Any such confidential material submitted to the Public Advisor will retain its confidential status. Nothing in this subsection shall require disclosure of privileged information.

The phrase "exact amount of time spent" as used in this subdivision refers either to five (5) minute or tenth (10th) of an hour increments.

(c) Parties may stipulate to a person's status as an intervenor. Parties shall not enter into a stipulation regarding whether a person has made a substantial contribution for the purpose of complying with section 2661 of this subchapter.

(d) The phrase "each specific task," as used in this subdivision refers to activities including, but is not limited to: (A) telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting or conference and the subject matter discussed; (B) legal pleadings or research, identifying the pleading or research and the subject matter; (C) letters, correspondence or memoranda, identifying the parties and the subject matter; and, (D) attendance at hearings, specifying when the hearing occurred, the subject matter of the hearing and the names of witnesses who appeared at the hearing, if any.

(e) Within 15 days after service of the request, any other party may submit a response to the request. The response shall be submitted to the Public Advisor and a copy shall also be provided to all parties to the proceeding. The intervenor or participant may reply to any such response within 15 days after service of the response. The reply shall be submitted to the Public Advisor and a copy shall also be provided to all parties to the proceeding.

(f) The Public Advisor shall require an audit and/or may inspect the books and records of the intervenor or participant to the extent necessary to verify the basis for the award. The Public Advisor shall maintain the confidentiality of the intervenor's books and records to the extent allowed by law.

(g) Any party questioning the market rate or reasonableness of any amount set forth in the request shall, at the time of questioning the market rate or reasonableness of that amount, provide a statement setting forth the fees, rates, and costs it expects to expend in the proceeding.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. New section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order, including amendment of section, transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).
6. Amendment filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2662.4. Amended Request for Award.

An intervenor or participant may submit amended requests for an award whenever it incurs additional fees or costs subsequent to the submission of a previous request for award. Any amended request shall meet the requirements of Section 2662.3 of this subchapter. Responses to an amended request, if any, shall meet the requirements of section 2662.3.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
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3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. New section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2662.5. Requirements for Awards.

(a) Subject to subdivision (b) herein, advocacy fees, witness fees, and other expenses of participation in a proceeding shall be awarded to any petitioner, intervenor or participant who complies with section 2662.3 and satisfies both of the following requirements:

(1) The petitioner, intervenor or participant's presentation makes a substantial contribution as evidenced by specific citations to the petitioner's, intervenor's or participant's direct testimony, cross–examination, legal arguments, briefs, motions, discovery, declarations by advocates and/or witnesses, written or oral comments of the intervenor or its witnesses regarding a rate application provided to the Department, correspondence with the parties, stipulations or settlement agreements, and decision or order by the Department or the Commissioner on a petition for hearing or rate or class plan application issued without a formal hearing, or any other appropriate evidence; and,

(2) The petitioner, intervenor or participant represents the interests of consumers.

(b) To the extent the substantial contribution claimed by a petitioner, intervenor or participant duplicates the substantial contribution of another party to the proceeding and was not authorized in the ruling on the Petition to Intervene or Participate, the petitioner's, intervenor's or participant's compensation may be reduced. Participation by the Department of Insurance staff does not preclude an award of compensation, so long as the petitioner's, intervenor's, or participant's substantial contribution to the proceeding does not merely duplicate the participation by the Department of Insurance's staff. In assessing whether there was duplication, the Commissioner will consider whether or not the petitioner, intervenor or participant presented relevant issues, evidence, or arguments which were separate and distinct from those presented by any party or the Department of Insurance staff.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95

or emergency language will be repealed by operation of law on the following day.

2. New section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
4. New section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order, including amendment of subsection (b), transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).
6. Amendment filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2662.6. Decision Awarding Compensation; Allowance of Award.

(a) In a written decision, the Commissioner shall determine whether or not the intervenor or participant has made a substantial contribution. The decision shall be issued within 90 days of receipt of all information required by Section 2662.3.

(b) If the Commissioner determines that the intervenor or participant has made a substantial contribution, the Commissioner shall set forth this substantial contribution and shall set forth the amount of compensation to be paid. The compensation awarded shall equal the market rate of the services provided.

(c) The Commissioner's decision shall be served on all parties to the proceeding.

(d) Any award paid by an applicant pursuant to this Article shall be allowed by the Insurance Commissioner as an expense for the purpose of establishing rates of the applicant as a dollar–for–dollar adjustment to rates approved by the Insurance Commissioner immediately on the determination of the amount of the award, so that the amount of the award shall be fully recovered within two years from the date of the award.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
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4. New section filed 5–30–96 as an emergency; operative 5–30–96 (Register 96, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–27–96 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2662.7. Time for Payment.

(a) Any award payable by an applicant shall be paid within 30 days of the decision awarding compensation. If an insurance company fails to pay an award within 30 days, the insurance company shall also pay interest on the amount awarded, at the legal rate, until the date on which the award is paid.

(b) For the purpose of this section, the phrase "within 30 days" shall mean within 30 days after the Insurance Commissioner issues a decision awarding compensation, unless the insurance company submits a timely petition for reconsideration or judicial challenge of the decision or any part for which compensation is sought by the intervenor, in which case no payment shall be required until 30 days after a decision on reconsideration or judicial challenge.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

HISTORY

1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12–19–95 as an emergency; operative 12–19–95 (Register 95, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–17–96 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–19–95 order transmitted to OAL April 17, 1996; disapproved by OAL and order of repeal as to 12–19–95 order filed 5–30–96 (Register 96, No. 22).
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5. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

§ 2662.8. Securing Payment.

The Commissioner shall make every reasonable effort to secure payment of award, including cooperating with other agencies of the state.

NOTE: Authority cited: Section 1861.10, Insurance Code; and *CalFarm Insurance Company, et al. v. George Deukmejian, et al.*, 48 Cal.3d 805, 824 (1989), *20th Century Insurance Company v. John Garamendi*, 8 Cal.4th 216, 281, 32 Cal. Rptr. 2d 807, 847 (1994). Reference: Sections 1861.10(a) and 1861.10(b), Insurance Code; and *CalFarm Insurance Company, et al.* v. *George Deukmejian, et al.*, 48 Cal.3d 805 (1989), *20th Century Insurance Company et al. v. John Garamendi* 8 Cal. 4th 216, 32 Cal. Rptr. 2d 807 (1994).

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1. New section filed 8–18–95 as an emergency; operative 8–18–95 (Register 95, No. 33). A Certificate of Compliance must be transmitted to OAL by 12–16–95 or emergency language will be repealed by operation of law on the following day.
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5. Certificate of Compliance as to 5–30–96 order transmitted to OAL 9–26–96 and filed 11–5–96 (Register 96, No. 45).

Subchapter 4.10. Rates for Credit Property Insurance and Credit Unemployment Insurance

Article 1. Scope

§ 2670.1. Authority.

This Subchapter is promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Sections 779.21, 779.36, 12921, and 12926 of the California Insurance Code, *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976), and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994).

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New subchapter 4.10 (articles 1–7, sections 2670.1–2670.24), article 1 (sections 2670.1–2670.3) and section filed 3–10–2003; operative 4–9–2003. Submitted

to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).

2. Change without regulatory effect withdrawing and repealing subchapter 4.10 (articles 1–7, sections 2670–.1–2670.24), article 1 (sections 2670.1–2670.3) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).

3. New subchapter 4.10 (articles 1–7, sections 2670.1–2670.24), article 1 (sections 2670.1–2670.3) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.2. Purpose.

The purpose of this Subchapter is to implement the provisions of Insurance Code Section 779.36 which apply to credit property insurance, joint credit property insurance, credit unemployment insurance and joint credit unemployment insurance.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Section 779.36, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.3. Applicability.

This Subchapter applies to all credit property insurance, joint credit property insurance, credit unemployment insurance, and joint credit unemployment insurance on risks or on operations in this state.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1851, 1861.01, 1861.05 and 1861.13, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).

[The next page is 728.53.]

2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Article 2. Definitions

§ 2670.4. Definitions Applicable to This Subchapter.

(a) "Credit property insurance" means insurance that provides coverage (generally coverage to repair or replace) on personal property pledged or offered as collateral for securing a personal or consumer loan, or personal property purchased under an installment sales agreement or through a credit transaction. Credit property insurance provides coverage for loss or damage to personal property caused by the perils set forth in the credit property insurance policy. Credit property insurance does not include creditor–placed insurance which is "force–placed" by a lender or creditor in the event the borrower or debtor fails to maintain insurance as required under his or her agreement with the lender or creditor. Credit property insurance does not include insurance which covers physical damage to an automobile or other motor vehicle, watercraft, or aircraft as a part of or in conjunction with a liability insurance policy.

(b) "Joint credit property insurance" means credit property insurance which insures two persons who are jointly liable to a lender or creditor. For purposes of these regulations, references to "credit property insurance" shall encompass both credit property insurance and joint credit property insurance.

(c) "Credit unemployment insurance" is insurance which provides coverage for periodic payments or payment of an outstanding balance on a specific loan or other credit transaction while the debtor is involuntarily unemployed, as defined in the policy.

(d) "Joint credit unemployment insurance" means credit unemployment insurance which insures two persons who are jointly liable to a lender or creditor. For purposes of these regulations, references to "credit unemployment insurance" shall encompass both credit unemployment insurance and joint credit unemployment insurance.

(e) "Closed end" plan of indebtedness is defined in CCR Section 2248.31(c).

(f) "Earned premium" means gross premium earned, including policy and membership fees, less return premium and premium on policies not taken.

(g) "Experience group" means the experience under a program of insurance of one creditor or more than one creditor. For purposes of defining and using the term "experience group," the following are separate programs of insurance: property; unemployment; open end or closed end; single premium or monthly premium; elimination period for unemployment; and retroactive or nonretroactive for unemployment. The insurance programs of each creditor in a multiple creditor group must be reasonably similar and each creditor's program must contain the same type of coverages and exclusions. If an experience group has experience in more than this State, an insurer may use only the experience of the experience group in California to rate the group or, with the approval of the Commissioner, an insurer may use the multi–state experience of the experience group for this purpose if it is more credible than the California experience and is generated by the same or similar programs of insurance and is adjusted to account for differences in premium rates. Insurers using multiple–creditor groups for the purpose of determining rates shall establish written standards for the inclusion of individual creditor–groups within such multiple creditor groups.

(h) "Experience period" means the most recent period of time for which experience is reported, but not for a period longer than three full years. If an experience group develops a Credibility Factor of 1 from TABLE 1 (the "Credibility Table" in Section 2670.9) in less than three years, the experience period for that case will be the number of full years needed to attain full credibility. Experience incurred in the period immediately preceding the effective date of this regulation may be used to the extent necessary to fill out the experience period. If a new experience group of an insurer has experience in this State with a prior insurer, the new insurer must use the most recent experience of the experience group with the prior insurer to the extent necessary to fill out an experience period. Other data or projections may be used if the Commissioner finds them to be more credible.

(i) "Reported Claim Count", as used in TABLE 1 (Section 2670.9), means the number of claims reported for the experience group during the experience period. This means the total number of claims reported during the experience period, whether paid or in the process of payment excluding claims without payment.

(j) "Open end" plan of indebtedness is defined in CCR Section 2248.31(*l*).

(k) "Prima facie rate" means the maximum rate which reasonably can be expected to provide the permissible loss ratio set forth in 2670.6. Prima Facie Rates and Permissible Loss Ratio for Benchmark Programs and which is not excessive, inadequate, unfairly discriminatory or otherwise in violation of Chapter 9 of the Insurance Code

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New article 2 (section 2670.4) and section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing article 2 (section 2670.4) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New article 2 (section 2670.4) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Article 3. Regulation of Rates

§ 2670.5. Presumptive Loss Ratios and Prima Facie Rates, Generally.

For the purpose of implementing Insurance Code Section 779.36, the presumptive loss ratio for credit property insurance coverage or for credit unemployment insurance coverage shall be the permissible loss ratio set forth in Section 2670.6, Prima Facie Rates and Permissible Loss Ratio for Benchmark Program computed by dividing incurred losses by earned premiums, using calendar year data. For the purpose of Insurance Code Section 1861.05, it shall be presumed that a rate is excessive if incurred losses cannot be reasonably expected to equal the appropriate percent of the earned premiums for each credit property insurance experience group or for each credit unemployment insurance experience group. These regulations contain prima facie rates and loss ratios based on the benchmark programs set forth in this Subchapter. An insurer may use a program which is different from a benchmark program provided the insurer shows that the proposed rate for the program is expected to produce a loss ratio of at least the appropriate percent set forth in Section 2670.6, Prima Facie Rates and Permissible Loss for Benchmark Programs.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New article 3 (sections 2670.5–2670.11) and section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing article 3 (sections 2670.5–2670.11) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court

No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).

3. New article 3 (sections 2670.5–2670.11) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.6. Prima Facie Rates and Permissible Loss Ratio for Benchmark Programs.

The prima facie rates and permissible loss ratio for the benchmark programs set forth in Sections 2670.12 through Section 2670.20 of these regulations are as follows:

(a) The prima facie rate for benchmark number one, Dual Interest Credit Property Insurance on Open End Plan of Indebtedness, is 2.9 cents per $100.00 of the monthly outstanding balance. The permissible loss ratio is 67%.

(b) The prima facie rate for benchmark number two, Dual Interest Credit Property Insurance on a Closed End Plan of Indebtedness, is $1.60 per $100.00 of the unpaid balance due at the time coverage attaches. The permissible loss ratio is 66%.

(c) The prima facie rate for benchmark number three, Dual Interest Credit Property Insurance on a Closed End Loan Secured by Personal Property, Invoiced Monthly, is 14 cents per $100.00 of the unpaid balance due at the time coverage attaches. The permissible loss ratio is 74%.

(d) [Reserved.]

(e) [Reserved.]

(f) The prima facie rate for benchmark number six, 30–Day Retroactive Credit Unemployment Insurance on an Open End Plan of Indebtedness, and Paying Minimum Monthly Payment, is 4.1 cents per $100.00 of the monthly outstanding balance. The permissible loss ratio is 64%.

(g) The prima facie rate for benchmark number seven, 30–Day Non–Retroactive Credit Unemployment Insurance on an Open End Plan of Indebtedness, and Paying Minimum Monthly Payment for Six Months, is 2.9 cents per $100.00 of the monthly outstanding balance. The permissible loss ratio is 65%.

(h) The prima facie rate for benchmark number eight, 30–Day Retroactive Credit Unemployment Insurance on an Installment Loan Plan of Indebtedness, paying Monthly Payment on Installment Loan Payments is $1.22 per $100.00 of the unpaid balance due at the time coverage attaches. The permissible loss ratio is 70%.

(i) The prima facie rate for benchmark number nine, 30–Day Non–Retroactive Credit Unemployment Insurance on an Open End Plan of Indebtedness, and Paying Outstanding Balance Up To Policy Limit, is 7 cents per $100.00 of the monthly outstanding balance. The permissible loss ratio is 66.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Section 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.7. Calculation of the Maximum Permitted Premium.

(a) Find the Credibility Factor ("Z") from TABLE 1 (Section 2670.9) for the experience group. Where actual loss ratios are less than 45%, use the premium earned for the experience group during the experience period; otherwise, use the Reported Claims Count. If either of these measures cannot be directly determined, the Commissioner may accept reasonable approximations of them.

(b) Calculate the credibility adjusted loss ratio ("CLR") for the experience group using the following formula, where ALR is the actual loss ratio for the experience group for the experience period adjusted to the prima facie rate level for the initial annual review and adjusted to the current effective rate level for subsequent annual reviews.

For credit unemployment insurance, the actual loss ratio for each year of the experience period shall be multiplied by the ratio of the prospective unemployment rate minus 3.0% to the historical unemployment rate for that year minus 3.0%. Each year the Commissioner shall determine the prospective and historical unemployment rates to be used.

$$CLR = Z\,(ALR) + .60(1-Z)$$

(c) Calculate the maximum permitted premium rate ("MaxPP") using the following formulas.

For the initial review:

$$MaxPP = CLR \times \text{Prima Facie Rate} / .6$$

For subsequent reviews:

$$MaxPP = CLR \times \text{Current Approved Rate} / .6$$

Rates shall be calculated and applied separately for property and unemployment.

(d) Credibility adjusted loss ratios and maximum permitted premium rates shall be redetermined annually.

(e) For the initial review, rates for programs whose provisions differ significantly from the benchmarks shall be set so that the loss ratio shall not be less than the permissible loss ratio set forth in Section 2670.6. Prima Facie Rates and Permissible Loss Ratio for Benchmark Programs and shall be approved by the Commissioner before their use. For subsequent reviews, the maximum permitted premium rate shall be calculated as above.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.8. Rate Changes.

(a) An insurer shall submit, for the Commissioner's approval, a proposed rate decrease for an experience group subject to this Subchapter within 180 days after the end of an experience period during which the credibility adjusted loss ratio for the group was less than the permissible loss ratio set forth in Section 2670.6. Prima Facie Rates and Permissible Loss Ratio for Benchmark Programs.

(b) An insurer may submit, for the Commissioner's approval, a proposed rate increase for an experience group subject to this Subchapter after the end of an experience period during which the credibility adjusted loss ratio for the group exceeded the permissible loss ratio set forth in Section 2670.6. Prima Facie Rates and Permissible Loss Ratio for Benchmark Programs.

(c) The proposed rate shall not exceed the maximum permitted premium rate.

(d) The Commissioner shall disapprove submission of a proposed rate if it is not demonstrated to him or her that the rate has been determined in accordance with applicable statutes and regulations. The Commissioner may approve a rate higher than the maximum permitted premium rate if it is demonstrated to his or her satisfaction that the maximum permitted premium rate provides inadequate allowances for acquisition costs, including commissions and other forms of compensation, expenses, profits, loss ratios, reserves, and other reasonable actuarial considerations.

(e) An approved rate decrease shall become effective for the experience group within 90 days of the Commissioner's approval. The Commissioner may approve a later effective date if it is demonstrated to him or her that the approved rate cannot reasonably be implemented within 90 days of his or her approval.

(f) An approved rate increase may become effective at any time after the Commissioner's approval or upon the 120th day after the submission of such proposal if it has not been disapproved by that day.

(g) An insurer assuming the business of some or all of the creditors comprising an experience group shall not use rates exceeding the rates of the prior insurer, except as provided in this Subchapter.

(h) An insurer may transfer a creditor from an experience group with a rate lower than the prima facie rate to another experience group only if the transfer would not result in a higher rate for the remainder of the former group.

(i) No insurer shall transfer a creditor group it already insures to an experience group with a rate higher than the prima facie rate. An insurer may assign a newly insured creditor group subject to a rate higher than the prima facie rate under its prior insurer into an experience group subject to a rate higher than the prima facie rate only if the assignment would not result in a higher rate for the newly–insured creditor group or the existing experience group.

(j) The Commissioner may consider proposals for rates in excess of the maximum permitted premium rates for specific creditors, creditor groups or products, if it is demonstrated to him or her that the maximum permitted premium rates provide inadequate allowances for acquisition costs, including commissions and other forms of compensation, expenses, profits, loss ratios, reserves, and other reasonable actuarial considerations, given the circumstances of the particular rate application.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.9. Table.

Table 1
Credibility Table

Earned Premium	*Reported Claim Count*	*Credibility Factor ("Z")*
1	1	.00
56,000	17	.25
81,000	24	.30
111,000	33	.35
145,000	43	.40
183,000	55	.45
226,000	68	.50
273,000	82	.55
325,000	98	.60
382,000	114	.65
443,000	133	.70
508,000	152	.75
578,000	173	.80
653,000	196	.85
732,000	220	.90
815,000	245	.95
903,000	271	1.00

The above integers represent the lower end of the bracket for each "Z" factor. The upper end is 1 less than the lower end for the next higher "Z" factor.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.10. Certificate of Insurance; Filing Requirements.

All coverages, exclusions, and limits of liability applicable to the certificate of insurance must be set forth in the certificate of insurance issued to the certificate holder. The coverages, exclusions, and limits of liability in the master policy which pertain to the certificate of insurance issued under the master policy must conform to the coverages, exclusions, and limits of liability set forth in the certificate of insurance issued under the master policy. Every rate filing subject to this Subchapter shall include copies of the certificate of insurance and master policy used in the program for which the rate filing is made.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.11. Cancellation of Coverage and Return Premium.

This section applies to all credit property insurance and credit unemployment insurance coverages except single interest credit property insurance coverage on closed end plans of indebtedness. In the event the certificate holder cancels coverage, any return premium shall be computed on a prorata basis if the premium is paid monthly, and by the Rule of 78's if the premium is a single payment premium and the coverage provided pays off the entire balance of the certificate holder's indebtedness.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 481(a), 779.36 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Article 4. Benchmark Programs for Credit Property Insurance

§ 2670.12. Benchmark Number One: Provisions for Dual Interest Credit Property Insurance on an Open End Plan of Indebtedness.

(a) When Coverage Is In Effect. Coverage is effective on the date the certificate of insurance holder's (the "certificate holder's") account has a balance, and continues for as long as there is an open balance in the account(s). Coverage ends on the date the certificate holder's account does not reflect an open balance, and is automatically reinstated when there is an open balance. Coverage will continue for up to 36 months from the date the item of personal property was financed. Coverage covers the insured property anywhere in the world.

(b) Coverage Provided. The insurance covers the interest of the master policyholder and the certificate holder in personal property purchased by the certificate holder and financed under an open end plan of indebtedness. In the event of a loss to a pair, set, or parts, the insurer will provide the following coverage: (1) For any article(s) that is a part of a pair or set: the insurer will pay a reasonable and fair proportion of the total value of the pair or set, with consideration given to the importance of such article(s). In no event will such loss mean total loss of the pair or set; (2) For any part of property which consists of several parts when complete: the insurer will be liable only for the value of the part lost or damaged.

(c) Perils Insured. The insurance provides coverage for direct and accidental loss or damage to insured personal property by fire; smoke; lightning; windstorm; cyclone; tornado; flood; hail; earthquake; explosion; riot; riot attending a strike; civil commotion; marine perils while on ferries and/or in cars or transfers in connection with land conveyances; aircraft; vehicles; collision; vandalism and malicious mischief; and burglary (of which there must be visible evidence of forced entry).

(d) Exclusions. Coverage will not apply to purchases made while the certificate holder is receiving benefits under the certificate.

(e) Limit of Liability. The insurance covers the interest of the master policy holder and the certificate holder up to the maximum(s) stated in the certificate of insurance. Coverage for any one account will be limited to the maximum amount per account as stated in the certificate of insurance. If the certificate holder has more than one account, the maximum limit stated in the certificate of insurance applies, and the total insurance provided under all of a certificate holder's accounts cannot exceed this amount. The insurer's limit of liability for loss is the cost to repair or replace the property insured at the time of the loss, not to exceed the following maximum limits: (1) for the first 60 days after enrollment for the insurance: an amount up to the highest balance in the certificate holder's open ended account during that 60–day period; and (2) after the first 60 days after enrollment for the insurance: an amount up to the highest balance on which a premium has been assessed during the 36 months before the date of loss. It is the insurer's option, after giving notice of its intention to do so within 60 days after the receipt of proof of loss to: (1) take all or any part of the property at the agreed or appraised value; or (2) repair, rebuild or replace the destroyed or damaged property with other of like kind and quality within a reasonable time.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New article 4 (sections 2670.12–2670.14) and section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing article 4 (sections 2670.12–2670.14) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New article 4 (sections 2670.12–2670.14) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.13. Benchmark Number Two: Provisions for Dual Interest Credit Property Insurance on a Closed End Plan of Indebtedness.

(a) When Coverage Is In Effect. Coverage is effective at 12:01 a.m. on the effective date specified in the certificate. The insurance attaches from the time the personal property is purchased or encumbered until the termination of the master policy holder's financial interest therein. Coverage applies within the United States and Canada, during transportation or otherwise, while the property is in the custody of the seller for packing or awaiting shipment or for repair or adjustment, and while in the custody of the certificate holder.

(b) Coverage Provided. The insurance covers the interests of the master policy holder and the certificate holder in personal property which is purchased by the certificate holder, in which the master policyholder has a financial interest, and which is financed under a closed end plan of indebtedness.

(c) Perils Insured. The insurance provides coverage for direct loss or damage to insured personal property by fire and lightning; collision (the coming together of cars during coupling not to be deemed a collision), derailment or overturning of a vehicle, collapse of bridges, while being transported by land conveyances; marine perils while on ferries and/or in cars or transfers in connection with land conveyances; burglary from within a building or room (of which there must be signs of forcible entry); and vandalism and malicious mischief. The insurance also provides extended coverage covering earthquake, windstorm, cyclone, tornado, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles, smoke, flood rising waters, tidal wave, high water or overflow, whether driven by wind or not, falling objects, collapse of building caused by weight of ice, snow, sleet or otherwise, rupture, cracking, burning or freezing of plumbing, heating or air–conditioning systems or domestic appliances, excluding domestic appliances for heating water for domestic consumption.

(d) Exclusions. Loss or damage to goods by decay, wet or dampness, or by being marred, scratched, spotted, discolored, moldy, rusty, frosted, rotted, steamed or changed in flavor; unless the same is the direct result of a peril insured against; mechanical breakdown; against loss or damage due to short–circuiting, blowout or other electrical disturbances within the article(s) insured; loss or damage caused by the neglect of the master policyholder or certificate holder to use all reasonable means to save and preserve the property at and after any disaster insured against, or when the property is endangered by fire in neighboring premises; loss or damage caused by or resulting from: (1) hostile or warlike action in time of peace or war, including action in hindering, combating or defending against an actual, impending or expected attack (a) by any government or sovereign power (de jure or de facto), or by any authority maintaining or using military, naval or air forces; or (b) by military, naval, or air forces; or (c) by an agent of any such government, power, authority or forces; (2) any weapon of war employing atomic fission or radioactive force whether in time of peace or war; (3) insurrection, rebellion, revolution, civil war, usurped power, or action taken by governmental authority in hindering, combating or defending against such an occurrence, seizure or destruction under quarantine or Customs regulations, confiscation by order of any governmental or public authority, or risks of contraband or illegal transportation or trade; loss or damage under any coverage due to radioactive contamination; loss or damage to aircraft, motor vehicles, and boats and any equipment pertaining thereto.

(e) Limit of Liability. The insurer shall not be liable for more than the amount stated in the certificate of insurance on property sold or encumbered for any one certificate holder. The insurer's limit of liability for loss or damage in the event of a partial loss is the cost to effect repair of the insured property, if the property is repairable. If the property is not repairable, the insurer will pay the cost of replacing the insured property with

no deduction for depreciation. The insurer will not be liable for more than the original amount of insurance stated in the certificate of insurance. The insurer's limit of liability for a total loss shall be the original amount of insurance stated in the certificate of insurance.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association v. John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.14. Benchmark Number Three: Provisions for Dual Interest Credit Property Insurance on a Closed End Loan Secured by Personal Property.

(a) When Coverage Is In Effect. Coverage is in effect for the term of years set forth in the certificate of insurance, from 12:01 a.m. on the effective date of coverage to 12:01 a.m. on the expiration date of coverage.

(b) Coverage Provided. The insurance covers the interest of the master policy holder and the certificate holder in personal property pledged as security for a closed end loan made by the master policy holder to the certificate holder, which property is specifically described in the security agreement.

(c) Perils Insured. The insurance provides coverage for loss or damage caused by fire and lighting; and collision or overturn, stranding, sinking, burning, or derailment, while the insured property is in transit. Extended coverage covers loss or damage due to: windstorm, cyclone, tornado, hail, rising water, tidal wave, overflow of water, earthquake, collapse of bridges, falling objects, or explosion; riot, riot attending a strike and civil commotion; aircraft or private passenger type vehicles; smoke; flood; collapse of building; rupture, cracking, burning or freezing of plumbing, heating or air conditioning systems and domestic appliances except for water heaters; and robbery or burglary with evidence of forced entry.

(d) Exclusions. Loss or damage due to: decay, wet or dampness, or by being marred, scratched, spotted, discolored, moldy, rusted or rotted unless the same is the direct result of a peril insured against; frost, cold weather, ice, snow or sleet; motor vehicles, land conveyances, farm equipment, aircraft or boats unless this coverage is provided; deterioration unless it results from insured perils; defective manufacturing, mechanical or electrical breakdown; the certificate holder's neglect of the property during and after any covered loss to the extent of the certificate holder's neglect; hostile or warlike action by any government or sovereign power, legal or actual, or their military authority or agent or by any armed forces; action taken by governmental authority in hindering, combating, or defending against such an occurrence; by nuclear reaction, nuclear radiation, or radioactive contamination; to all forms of money or instruments; or to television antennas and outside wiring.

(e) Limit of Liability. The insurer's limit of liability for loss or damage in the event of a partial loss will be equal to the actual cash value of the insured property, not to exceed the cost to repair or replace the insured property with property of like kind or quality. The insurer's limit of liability in the event of a total loss will be equal to the lesser of the actual cash value of the insured property or the original amount of insurance. Coverage will not exceed the maximum limit of liability stated in the certificate of insurance.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association v. John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Article 5. Benchmark Provisions for Credit Unemployment Insurance

§ 2670.17. Benchmark Number Six: Provisions for 30–Day Retroactive Credit Unemployment Insurance on an Open End Plan of Indebtedness, and Paying Minimum Monthly Payment.

(a) When Coverage Is In Effect. Coverage is in effect from the time the certificate holder's account has a balance and continues as long as there is an open balance in the account(s). Insurance coverage will cease when the certificate holder's account does not reflect an open balance, and will be automatically reinstated when there is an open balance.

(b) Coverage Provided. The insurance covers the interests of the master policyholder and the certificate holder in connection with purchases under an account agreement. All benefits apply to account payments and will be paid to the master policy holder to pay off or reduce the certificate holder's debt. The insurer will pay the minimum monthly payment on the certificate holder's account if he or she is unemployed for more than 30 consecutive days. After the 30–day waiting period benefits will be paid retroactively to the first day of unemployment and while the unemployment continues.

(c) Perils Insured. The insurer will pay benefits for loss of the certificate holder's employment income resulting from involuntary loss of employment, or unemployment due to labor disputes, strikes, or lockouts.

(d) Exclusions. Coverage will not apply to loss of income due to retirement or disability. Coverage will not apply to purchases made while the certificate holder is receiving benefits under his or her certificate.

(e) Limit of Liability. The insurance covers the interest of the master policy holder and the certificate holder up to the maximum(s) stated in the certificate of insurance. Coverage for any one account will be limited to the maximum amount per account as stated in the certificate of insurance. If the certificate holder has more than one account, the maximum limit stated in the certificate of insurance applies, and the total insurance provided under all of a certificate holder's accounts cannot exceed this amount.

(f) Eligibility. To be eligible for loss of employment income benefits, as of the effective date of the certificate the certificate holder must be insured under the plan and gainfully employed on a full–time basis in a nonseasonal occupation. To receive loss of employment income benefits, the certificate holder must verify that he or she registered with his or her state's unemployment office or a recognized employment agency. Registration must begin within 15 days after the date of involuntary unemployment and continue for the entire period of the claim. Coverage will not be denied if the certificate holder does not qualify because his or her former employer was not required to contribute to the state unemployment fund. A certificate holder will be reeligible for unemployment benefits after the completion of payments under a loss of employment claim if he or she has been gainfully employed on a full–time basis in a nonseasonal occupation for a period of 30 consecutive days.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New article 5 (sections 2670.17–2670.20) and section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing article 5 (sections 2670.17–2670.20) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New article 5 (sections 2670.17–2670.20) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.18. Benchmark Number Seven: Provisions for 30–Day Non–Retroactive Credit Unemployment Insurance on an Open End Plan of Indebtedness, and Paying Minimum Monthly Payment for Six Months.

(a) When Coverage Is In Effect. Coverage is in effect from the time the certificate holder's account has a balance and continues as long as there is an open balance in the account(s). Insurance coverage will cease when the certificate holder's account does not reflect an open balance, and will be automatically reinstated when there is an open balance.

(b) Coverage Provided. The insurance covers the interests of the master policyholder and the certificate holder in connection with purchases under an account agreement. All benefits apply to account payments and will be paid to the master policyholder to pay off or reduce the certificate holder's debt. The insurer will pay the minimum monthly payment on the certificate holder's account if he or she is unemployed for more than 30 consecutive days. After the 30–day waiting period, benefits will be paid beginning on the 31st day, and while the unemployment continues, up to a maximum of six months.

(c) Perils Insured. The insurer will pay benefits for loss of the certificate holder's employment income resulting from involuntary loss of employment, or unemployment due to labor disputes, strikes, or lockouts.

(d) Exclusions. Coverage will not apply to loss of income due to retirement. Coverage will not apply to purchases made while the certificate holder is receiving benefits under his or her certificate.

(e) Limit of Liability. The insurance covers the interest of the master policyholder and the certificate holder up to the maximum(s) stated in the certificate of insurance. Coverage for any one account will be limited to the maximum amount per account as stated in the certificate of insurance. If the certificate holder has more than one account, the maximum limit stated in the certificate of insurance applies, and the total insurance provided under all of a certificate holder's accounts cannot exceed this amount.

(f) Eligibility. To be eligible for loss of employment income benefits, as of the effective date of the certificate the certificate holder must be insured under the plan and gainfully employed on a full–time basis in a nonseasonal occupation. To receive loss of employment income benefits, the certificate holder must verify that he or she registered with his or her state's unemployment office or a recognized employment agency. Registration must begin within 15 days after the date of involuntary unemployment and continue for the entire period of the claim. Coverage will not be denied if the certificate holder does not qualify because his or her former employer was not required to contribute to the state unemployment fund. A certificate holder will be reeligible for unemployment benefits after the completion of payments under a loss of employment claim if he or she has been gainfully employed on a full–time basis in a nonseasonal occupation for a period of 30 consecutive days.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.19. Benchmark Number Eight: Provisions for 30–Day Retroactive Credit Unemployment Insurance on an Installment Loan Plan of Indebtedness, Paying Monthly Payment on Installment Loan up to Twelve Monthly Payments.

(a) When Coverage Is In Effect. Coverage is in effect for the term of years set forth in the certificate of insurance, from 12:01 a.m. on the effective date of coverage to 12:01 a.m. on the expiration date of coverage.

(b) Coverage Provided. The insurer will pay loss payment benefits to the master policyholder for the benefit of the certificate holder's account on a loan agreement or sales contract between the certificate holder and the master policyholder. The loan agreement or sales contract must provide for equal monthly installment payments or loans with a variable interest feature, or loans with a balloon payment. For loans with a variable interest rate of loans with a balloon payment the monthly benefit will not exceed the original monthly payment amount. The balloon payment is not covered. The insurer will pay the certificate holder's scheduled monthly payment on the loan agreement or sales contract if the certificate holder is involuntarily unemployed for at least 30 consecutive days. After the 30–day waiting period the insurer will pay the scheduled monthly payment retroactively to the first day of unemployment and while the unemployment continues. The scheduled monthly payment on the certificate holder's indebtedness must be at least 30 days delinquent for coverage to begin.

(c) Perils Insured. The insurer will pay benefits for loss of the certificate holder's employment income resulting from involuntary loss of employment, or unemployment due to labor disputes, strikes, or lockouts.

(d) Exclusions. Coverage does not apply to voluntary forfeiture of salary, wages, or employment income; resignation; retirement whether voluntary or mandatory; disability caused by accident, sickness, disease or pregnancy; or termination as the result of willful misconduct or criminal misconduct.

(e) Limit of Liability. The insurer will pay the scheduled monthly benefit or an amount equal to 1/30th of the scheduled monthly benefit for each day of a period less than thirty days which the certificate holder are involuntarily unemployed. The insurer will go back to the first day of the certificate holder's eligibility to count the number of days. The total of all payments is limited to the schedule shown in the table below. If the certificate holder's loss of employment occurs during the first 60 days after inception of coverage the maximum number of payment benefits payable during that period of involuntary unemployment will be one–half of the total benefits payable as provided in the schedule.

The maximum number of monthly benefits provided shall not exceed the remaining originally scheduled total of loan payments at the time of loss. In the event that the certificate holder's loan or credit agreement is extended or modified in any manner, the insurer's liability will never be more that the total amount of monthly benefits that would have been provided without such modification or extension.

Term of Loan	*Maximum Benefits Payable for Loss After 60 Days*	*Maximum Number of Benefits Payable for Loss Within the 1st 60 days*
1–13 months	4	2
14–19 months	5	2.5
20–25 months	6	3
26–31 months	7	3.5
32–37 months	8	4
38–43 months	9	4.5
44–49 months	10	5
50–55 months	11	5.5
56–61 months	12	6

No more that the total monthly benefits shown above will be payable during the term of coverage. It will include all amounts paid for involuntary unemployment, whether during one or more periods of unemployment.

(f) Eligibility

To be eligible for loss of employment income benefits, as of the effective date of the certificate the certificate holder must be gainfully employed for at least 12 consecutive months except for vacation time, prior to the effective date of this coverage, except employment interruption for less than 30 consecutive days during the previous 12 month period or employment interrupted by lockout, general strike, or unionized labor dispute shall not eliminate a certificate holder from eligibility. Self–employed individuals or independent contractors or seasonal employees are not eligible for coverage. To receive loss of income benefits, the certificate holder must qualify for unemployment benefits under his or her state's unemployment laws and must register for work with his or her state employment office or a recognized employment agency within 15 days after the last day employed and remain so registered during the claim period if the loss of employment occurred as the result of either layoff or employer termination; or provide the insurer with verification of loss which occurred as the result of a general strike, unionized labor dispute or lockout from sources as determined by the insurer at the time of loss. Coverage will not be denied if the certificate holder does not qualify for state unemployment benefits because his or her former employer was not required to contribute to the state unemployment fund. Re–eligibility for remaining benefits will begin on the 1st day of unemployment if the employment period is less than 30 days. If the unemployment period is greater than 30 days, eligibility for payment will begin after the 30th day of unemployment.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.20. Benchmark Number Nine: Provisions for 30–Day Non–Retroactive Credit Unemployment Insurance on an Open End Plan of Indebtedness, and Paying Outstanding Balance up to Policy Limit.

(a) When Coverage Is In Effect. Coverage is in effect from the time the account has an open balance and continues as long as there is an open balance in the certificate holder's account(s). The insurance will cease when the certificate holder's account does not reflect an open balance, and will be automatically reinstated when there is an open balance.

(b) Coverage Provided. The insurance covers the interests of the master policyholder and the certificate holder in connection with purchases under an account agreement. The insurer will pay benefits for loss of employment income of the certificate holder resulting from involuntary unemployment. The benefits payable will apply to account payments. The benefit provided will be the amount of the outstanding balance as of the date of loss, or the maximum amount per account indicated in the certificate, whichever is less. Benefits will be paid after expiration of the 30–day waiting period specified in the certificate.

(c) Perils Insured. The insurer will pay a loss of employment income benefit if the certificate holder (1) has an involuntary loss of employment; or (2) is unemployed due to labor disputes; and (3) remains involuntarily unemployed for longer than the benefit waiting period of 30 days.

(d) Exclusions. There is no coverage for loss of income due to retirement. Coverage will not apply to purchases made by the certificate holder during the claim period.

(e) Limit of Liability. The insurance covers the interests of the master policyholder and the certificate holder up to the maximum(s) stated in the certificate. Coverage for any one account will be limited to the maximum amount per account as shown in the certificate. If the certificate holder has more than one account, the maximum limit shown in the certificate applies, and the total insurance provided under all of a certificate holder's accounts cannot exceed this amount.

(f) Eligibility

To be eligible for loss of employment income benefits, the certificate holder must be insured under the plan and gainfully employed on a full–time basis in a nonseasonal occupation at the time of loss. To receive loss of income benefits, the certificate holder must verify during the specified period of unemployment that he or she registered with his or her state unemployment office or a recognized employment agency. Registration must begin within 15 days after the date of involuntary unemployment and continue for the entire period of the claim Coverage will not be denied if the certificate holder does not qualify for state unemployment benefits because his or her former employer was not required to contribute to the state unemployment fund.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Article 6. Reporting Requirements

§ 2670.21. Annual Experience Reports.

(a) Each insurer subject to this Subchapter shall file an annual report of its credit property insurance and credit unemployment insurance experience statistics with the Commissioner no later than May 1 of the year following the calendar year reported. All annual reports of experience statistics shall be filed with the California Department of Insurance, Rate Regulation Division, Rate Specialist Bureau, 300 South Spring Street, 14th Floor, Los Angeles, California 90013.

(b) Each type of insurance as defined in this Subchapter shall be reported separately on the Credit Property Insurance Experience Report and Credit Unemployment Insurance Experience Report forms prescribed by the Commissioner. The experience report for insurance programs not defined in this Subchapter shall include brief descriptions of

the coverages provided. The experience for each type of coverage shall be reported separately. The Commissioner reserves the right to require that the reports be filed in electronic media form. Each insurer shall maintain experience data on an annual basis for its business subject to this Subchapter for at least five (5) years. Experience statistics generated under conditions different from those assumed in this Subchapter shall be reported separately.

(c) Credit insurance experience generated by business issued before the effective date of this Subchapter shall be maintained and reported separately from experience generated under this Subchapter.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Section 779.36, Insurance Code.

HISTORY

1. New article 6 (sections 2670.21–2670.22) and section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 10).
2. Change without regulatory effect withdrawing and repealing article 6 (sections 2670.21–2670.22) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New article 6 (sections 2670.21–2670.22) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.22. Reporting Forms.

The Credit Property Insurance Experience Report form and the Credit Unemployment Insurance Experience Report form are available as downloadable forms on the Department of Insurance web site at http://www.insurance.ca.gov. If the forms cannot be successfully downloaded from the web site, they may be obtained by contacting the address below:

CALIFORNIA DEPARTMENT OF INSURANCE
RATE REGULATION BRANCH, RATE SPECIALIST BUREAU
300 SOUTH SPRING STREET, 14TH FLOOR
LOS ANGELES, CA 90013.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Section 779.36, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Article 7. Effective Date and Severability

§ 2670.23. Effective Date.

Every insurer subject to this Subchapter shall seek approval of its rates sixty (60) days after the effective date of these regulations. Credit property and credit unemployment rate filings shall be reviewed under Insurance Code Sections 779.36, 1861.01(c), 1861.05, and any other applicable law.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New article 7 (section 2670.23–2670.24) and section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing article 7 (sections 2670.23–2670.24) and section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New article 7 (section 2670.23–2670.24) and section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

§ 2670.24. Severability.

If any provision of this Subchapter or its application to any person or circumstance is held invalid for any reason, the rest of this Subchapter shall not be affected.

NOTE: Authority cited: Sections 779.21, 779.36, 12921 and 12926, Insurance Code; *Credit Insurance General Agents Association v. Payne*, 16 Cal.3d 651 (1976); and *20th Century v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 779.36, 1861.01 and 1861.05, Insurance Code.

HISTORY

1. New section filed 3–10–2003; operative 4–9–2003. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2003, No. 11).
2. Change without regulatory effect withdrawing and repealing section pursuant to settlement agreement in *Consumer Credit Insurance Association* v. *John Garamendi* (California Superior Court No. 03CS00533) filed 5–27–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 22).
3. New section filed 4–28–2006; operative 5–28–2006. Submitted to OAL for printing only pursuant to Government Code section 11343.8 as a regulation that establishes rates in accordance with Government Code section 11340.9(g) (Register 2006, No. 17).

Subchapter 5. Stock Insurers—Corporate Affairs

Article 1. Proxies, Consents and Authorizations of Domestic Insurers

§ 2680.1. Application of Article.

This Article is applicable to all domestic stock insurers having 100 or more stockholders; provided, however, that this Article shall not apply to any insurer if 95% or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than 500 stockholders. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934 and the Securities Exchange Act Amendments of 1964 and Regulation X–14 of the Securities and Exchange Commission promulgated thereunder shall be exempt from the provisions of this Article.

NOTE: Authority cited: Section 1140.5, Insurance Code.

HISTORY

1. New Subchapter 5 (Sections 2680.1 through 2680.7, 2680.9 through 2680.13) filed 9–20–65; effective thirtieth day thereafter (Register 65, No. 18).

§ 2680.2. Proxies, Consents and Authorizations.

No domestic stock insurer, or any director, officer or employee of such insurer subject to Section 2680.1 hereof, or any other person, shall solicit, or permit the use of his name to solicit by mail or otherwise, any proxy, consent or authorization in respect of any stock of such insurer in contravention of this Article and Schedules A and B hereof as set forth in Section 2680.12 and 2680.13, respectively.

§ 2680.3. Disclosure of Equivalent Information.

Unless proxies, consents or authorizations in respect of a stock of a domestic insurer subject to Section 2680.1 hereof are solicited by or on behalf of the management of such insurer from the holders of record of stock of such insurer in accordance with this Article and the Schedules hereunder prior to any annual or other meeting, such insurer shall, in accordance with this Article and/or such amendments hereto as the Com-

missioner may adopt, file with the Commissioner and transmit to all stockholders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

§ 2680.4. Definitions.

(1) The definitions and instructions set out in Schedule Stockholder Information Supplement, as promulgated by the National Association of Insurance Commissioners, shall be applicable for purposes of this Article.

(2) The terms "solicit" and "solicitation" for purposes of this Article shall include:

(a) any request for a proxy, whether or not accompanied by or included in a form of proxy; or

(b) any request to execute or not to execute, or to revoke, a proxy; or

(c) the furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(3) The terms "solicit" and "solicitation" shall not include:

(a) any solicitation by a person in respect to stock of which he is the beneficial owner;

(b) action by a broker or other person in respect to stock carried in his name or in the name of his nominee in forwarding to the beneficial owner of such stock soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

(c) the furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

(4) Unless the context otherwise requires, the words used in this Article which are defined in Sections 1 to 42 of the Insurance Code shall, insofar as applicable, have the same meanings as therein defined, and the following words shave have meanings as follows:

(a) The words "parent" and "subsidiary" as applied to corporations shall have the same meanings as "holdings corporation" and "subsidiary corporation," respectively, as defined in Section 118 of the Corporations Code.

(b) The word "affiliate" means any person that directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with the person to which such "affiliate" is related.

(c) The word "associate" used to indicate a relationship with any persons, means

(1) any corporation or organization (other than the issuer of the securities as to which a proxy hereunder is solicited, or a majority–owned subsidiary of such issuer) of which such person is an officer or partner or is, directly or indirectly, the beneficial owner of ten percent or more of any class of equity securities,

(2) any trust or other estate in which such person has a substantial beneficial interest or as to which such person serves as trustee or in a similar fiduciary capacity, and

(3) any relative or spouse of such person, or any relative of such spouse, who has the same home as such person, or any relative of such spouse, who has the same home as such person or who is a director or officer of the issuer or any of its parents or subsidiaries.

§ 2680.5. Information to Be Furnished to Stockholders.

(1) No solicitation subject to this Article shall be made unless each person solicited is concurrently furnished or has previously been furnished with as a written proxy statement containing the information specified in Schedule A as set forth in Section 2680.12 hereof.

(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection 1 hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule Stockholder Information Supplement under heading "Financial Reporting to Stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

(3) Two copies of each report sent to the stockholders pursuant to this section shall be mailed to the Commissioner not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the Commissioner pursuant to subsection 1 of Section 2680.7, whichever date is later.

§ 2680.6. Requirements As to Proxy.

(1) The form of proxy

(a) shall indicate in boldface type whether or not the proxy is solicited on behalf of the management,

(b) shall provide a specifically designated blank space for dating the proxy and

(c) shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or stockholders.

No reference need to be made to proposals as to which discretionary authority is conferred pursuant to Subsection 3 hereof.

(2) Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in boldface type how it is intended to vote the shares or authorization represented by the proxy in each such case.

(3) A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

(4) No proxy subject to Section 1140.5 of the Insurance Code and this Article shall confer authority

(a) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or

(b) to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

(5) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specified by means of ballot provided pursuant to

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subsection 2 hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

(6) The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements shall be clearly and legibly presented.

§ 2680.7. Material Required to Be Filed.

(1) Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the Commissioner at least 10 days prior to the date definitive copies of such material are first sent or given to stockholders, or such shorter period prior to that date as the Commissioner may authorize upon a showing of good cause thereof.

(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the Commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the Commissioner may authorize upon a showing of good cause therefor.

(3) Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the Commissioner not later than the date such material is first sent or given to the stockholders.

(4) Where any proxy statement, form of proxy or other material filed pursuant to these rules is amended or revised, two of the copies shall be marked to clearly show such changes.

(5) Copies of replies to inquires from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

(6) Notwithstanding the provisions of subsections 1 and 2 hereof and of Subsection 5 of Section 2680.11, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by Subsection 3 hereof not later than the date such material is used or published. The provisions of subsections 1 and 2 hereof and Subsection 5 of Section 2680.11 shall apply, however, to any reprints or reproductions or all or any part of such material.

§ 2680.9. False or Misleading Statements.

No solicitation subject to this Article shall be made by means of any proxy statement, form of proxy, notice of meeting, or other communication, written or oral, containing any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the solicitation of a proxy for the same meeting or subject matter which has become false or misleading.

§ 2680.10. Prohibition of Certain Solicitations.

No person making a solicitation which is subject to this Article shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

§ 2680.11. Special Provisions Applicable to Election Contests.

(1) Applicability.

This section shall apply to any solicitation subject to this Article by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

(2) Participant or Participant in a Solicitation.

(a) for purposes of this section the terms "participant" "participant in a solicitation" include:

(i) the insurer;

(ii) any director of the insurer, and any nominee for whose election as a director proxies are solicited;

(iii) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(b) For the purpose of this section the terms "participant" and "participant in a solicitation" do not include:

(i) a bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant;

(ii) any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties;

(iii) any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;

(iv) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or

(v) any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

(3) Filing of Information Required by Schedule B.

(a) No solicitation subject to this section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the Commissioner may authorize upon a showing of good cause therefor, there has been filed with the Commissioner by or on behalf of each participant in such solicitation a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Commissioner's comments have been received and complied with.

(b) Within five business days after a solicitation subject to this section is made by the management of an insurer, or such longer period therefor, there shall be filed with the Commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, then, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the Commissioner by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a) (b) and (c) of this subsection, additional persons become participants in a solicitation subject to this rule, there shall be filed with the Commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as the Commissioner may authorize upon a showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the Commissioner.

(f) Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the Commissioner.

(4). Solicitations Prior to Furnishing Required Written Proxy Statement.

Notwithstanding the provisions of subsection 1 of Section 2680.6, a solicitation subject to this section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Schedule A with respect to such solicitation. provided that—

(a) The statements required by subsection 3 hereof are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to stockholders prior to the time the written proxy statement required by subsection 1 of Section 2680.5 is furnished to such persons; provided, however, that this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to stockholders.

(c) At least the information specified in paragraphs (b) and (c) of the statements required by subsection 3 hereto to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given stockholders at the earliest practicable date.

(5) Solicitations Prior to Furnishing Required Written Proxy Statement—Filing Requirements.

Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by subsection 1 of Section 2680.5 shall be filed with the Commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the Commissioner may authorize upon a showing of good cause therefor.

(6) Application of This Section to Report.

Notwithstanding the provisions of subsections 2 and 3 of Section 2680.5, two copies of any portion of the report referred to in subsection 2 of Section 2680.5 which comments upon or refers to any solicitation subject to this section, or to any participant in such solicitation, other than the solicitation by the management, shall be filed with the Commissioner as proxy material subject to this regulation. Such portion of the report shall be filed with the Commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to stockholders.

SCHEDULE A
INFORMATION REQUIRED IN
PROXY STATEMENT

§ 2680.12. Items of Information Required.

Item 1. Revocability of Proxy.

State whether or not the person giving the proxy has the power to revoke it. If the right or revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

Item 2. Dissenters' Right of Appraisal.

Outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such stockholders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

Item 3. Persons Making Solicitations Not Subject to Section 2680.11.

(1) If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action which he intends to oppose.

(2) If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

(3) If the solicitation is to be made by specially engaged employees or paid solicitor, state

(i) the material features of any contract or arrangement for such solicitation and identify the parties, and

(ii) the cost or anticipated cost thereof.

Item 4. Interest of Certain Persons in Matters to Be Acted Upon.

Describe briefly any substantial interest, direct or indirect, by stockholders or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

Item 5. Stocks and Principal Stockholders.

(1) State, as to each class of voting stock of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

(2) Give the date as of which the record list of stockholders entitled to vote at the meeting will be determined. If the right to vote is not limited to stockholders of record on that date, indicate the conditions under which other stockholders may be entitled to vote.

(3) If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

Item 6. Nominees and Directors.

If action is to be taken with respect to the election of directors furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a directors at the meeting.

(a) Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and officer with the insurer presently held by him, and indicate which persons are nominees for election as directors at the meeting.

(b) State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of stockholders at a meeting for which proxies were solicited under this Article.

(c) If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

(d) State, as of the most recent practicable date, the approximate number, and the approximate portion thereof to the total number, of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such stocks make a statement to that effect.

Item 7. Remuneration and Other Transactions with Management and Others.

Furnish the information reported or required in Item 1 of Schedule Stockholder Information Supplement under the heading "Information Regarding Management and Directors" if action is to be taken with respect to

(a) the election of directors,

(b) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate,

(c) any pension or retirement plan in which any such person will participate, or

(d) the granting of extension to any such person of any options, warrants or rights to purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro rata basis. If the solicitation is made on behalf of persons other than the management information shall be fur-

nished only as to Item IA of the aforesaid heading of Schedule Stockholder Information Supplement. (Note that said Schedule "SIS" requires that the remuneration, direct and by other means is required to be shown as to each director, irrespective of the amount thereof).

Item 8. Bonus, Profit–Sharing and Other Remuneration Plans.

If action is to be taken with respect to any bonus, profit–sharing, or other remuneration plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) The amounts which would have been distributable under the plan during the last calendar year to

(1) each person named in Item 7 of this Schedule,

(2) directors and officers as a group, and

(3) to all other employees as a group, if the plan had been in effect.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in Paragraph (b) of this item, the nature of such amendments should be specified.

Item 9. Pension and Retirement Plans.

If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) State

(1) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period;

(2) the estimated annual payment to be made with respect to current services;

(3) the amount of such annual payments to be made for the benefit of

(i) each person named in Item 7 of this Section,

(ii) directors and officers as a group, and

(iii) employees as a group.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocations of the benefits as between the groups specified in subparagraph (b) (3) of this Item, the nature of such amendments should be specified.

Item 10. Options, Warrants, or Rights.

If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all stockholders on a pro rata basis, furnish the following information:

(a) The title and amount of stock called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

(b) If known, state separately the amount of stock called for or to be called for by warrants received or to be received by the following persons, naming each such person:

(1) each person named in Item 7 of this Schedule, and

(2) each other person who will be entitled to acquire five percent or more of the stock called for or be called for by such warrants.

(c) If known, state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11. Authorization or Issuance of Stock.

(1) If action is to be taken with respect to the authorization or issuance of any stock of the insurer furnish the title, amount and description of the stock to be authorized or issued.

(2) If the shares of stock are other than additional shares of common stock if a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

(3) If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial statements comparable to those contained in the annual statement filed by the insurer with him.

Item 12. Mergers, Consolidations, Acquisitions and Similar Matters.

(1) If action is to be taken with respect to a merger, consolidation, acquisition or similar matter, furnish in brief outline the following information:

(a) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting stockholders in order to perfect such rights.

(b) The material features of the plan or agreement.

(c) The business done by the company to be acquired or whose assets are being acquired.

(d) If available, the high and low sales prices for each quarterly period within two years.

(e) The percentage of outstanding shares which must approve the transaction before it is consummated.

(2) For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(a) A comparative balance sheet as of the close of the last two fiscal years.

(b) A comparative statement of operating income and expenses for each of the last two years and, as a continuation of each statement, a statement of earning per share, after related taxes, and cash dividends paid per share.

(c) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13. Restatement of Accounts.

If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information:

(a) State the nature of the restatement and the date as of which it is to be effective.

(b) Outline briefly the reasons for the restatement and for the selection of the particular effective date.

(c) State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item 14. Matters Not Required to Be Submitted.

If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, state the nature of such matter, the reason for submitting it to a vote of stockholders and what action is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

Item 15. Amendment of Charter, By–Laws, or Other Documents.

If action is to be taken with respect to any amendment of the insurer's charter, by–laws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

SCHEDULE B

INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF OF A PARTICIPANT (OTHER THAN THE INSURER) IN A PROXY SOLICITATION IN AN ELECTION CONTEST

§ 2680.13. Items of Information Required—Election Contest.

Item 1. Insurer.

State the name and address of the insurer.

Item 2. Identity and Background.

(a) State the following:

(1) Your name and business address

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(b) State the following:

(1) Your residence address.

(2) Information as to all material occupations, positions, offices or employments during the last 10 years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

(c) State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

(d) State whether or not, during the past 10 years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub–item need not be included in the proxy statement or other proxy soliciting material.

Item 3. Interest in Stock of the Insurer.

(a) State the amount of each class of stock of the insurer which you own beneficially, directly or indirectly.

(b) State the amount of each class of stock of the insurer which you own of record but not beneficially.

(c) State with respect to the stock specified in (a) and (b) the amounts acquired within the past two years, the dates of acquisition and the amounts acquired on each date.

(d) If any part of the purchase price or market value of any of the stock specified in Paragraph (c) is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

(e) State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom such contracts, arrangements or understanding exist and give the details thereof.

(f) State the amount of stock of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.

(g) State the amount of each class of stock of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

Item 4. Further Matters.

(a) Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

(b) Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

(c) State whether or not you or any of your associates have any arrangement or understanding with any person—

(1) with respect to any future employment by the insurer or its subsidiaries or affiliates; or

(2) with respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangement or understanding and state the names of the parties thereof.

Item 5. Signature.

The statement shall be dated and signed in the following manner:

Signed at _____, _____
(City) (State)

On_____
(Date)

_____
(Signature of Participant
or Authorized Representative)

Article 2. Insider Trading

§ 2682.1. Definition of Certain Terms.

(a) "Insurer" means any domestic stock insurance company, with an equity security subject to the provisions of Section 1104.2 to 1104.8, both inclusive, of the California Insurance Code, and not exempt thereunder.

(b) Section numbers refer to sections of the California Insurance Code unless the context of the reference otherwise requires. Sections 1104.2 to 1104.8, both inclusive, are the provisions relating to insider trading enacted by Chapter 38 of the Statutes of 1965.

(c) "Officer" means a president, vice president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

(d) "Equity security" means any stock or similar security; or any voting trust certificate or certificate of deposit for such a security; or any security convertible, with or without consideration into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right.

(e) Securities "held of record."

(1) For the purpose of determining whether Section 2682.2 herein is applicable to the equity security holders of an insurer because, pursuant to the provisions of Section 1104.8 the equity securities of such insurer are held of record by one hundred or more persons, securities shall be deemed to be "held of record" by each person who is identified as the owner of such securities on record of security holders maintained by or on behalf of the insurer, subject to the following:

(a) In any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as such as owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record.

(b) Securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person.

(c) Securities identified as held of record by one or more persons in trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person.

(d) Securities held by two or more persons as co–owners shall be included as held by one person.

(e) Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if such securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of persons.

(f) Securities registered in substantially similar names where the insurer has reason to believe because of the address or other indications that such names represent the same person, may be included as held of record by one person.

(2) Notwithstanding subsection (1) of this paragraph:

(a) Securities held, to the knowledge of the insurer, subject to a voting trust, deposit, agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in such securities; *provided however,* that the insurer may rely in good faith on such information as it received in response to its request from a non–affiliated insurer of the certificates or evidences of interest.

(b) If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of Section 1104.2 to 1104.8, the beneficial owners of such securities shall be deemed to be the record owners thereof.

(f) "Class" means all securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges.

NOTE: Authority cited for Article 2: Sections 1104.2, 1104.3, 1104.5, 1104.6 and 1104.7, Insurance Code.

HISTORY

1. New Section 2682.1 filed 11–10–65; effective thirtieth day thereafter (Register 65, No. 18).
2. Repealer of Section 2682.1 and new Article 2 (Sections 2682.1 through 2682.22) filed 1–18–66; effective thirtieth day thereafter (Register 66, No. 2).

§ 2682.2. Transactions Exempted from the Operation of Section 1104.3.

Any acquisition or disposition of any equity security by a director or officer or an insurer within six months prior to the date on which Sections 1104.2 and 1104.8 shall first become applicable with respect to the equity securities of such insurer shall not be subject to the operation of Section 1104.3.

§ 2682.3. Filing of Statements.

Initial statements of beneficial ownership of equity securities required by Section 1104.2 shall be filed on Form A, attached hereto. Statements of changes in such beneficial ownership required by said Section 1104.2 shall be filed on Form B, attached hereto. All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

STATE OF CALIFORNIA
INSURANCE COMMISSIONER
FORM A

INITIAL STATEMENT OF BENEFICIAL OWNERSHIP OF SECURITIES
Filed pursuant to Sections 1104.2–1104.8, Insurance Code.

_____
(Name of insurance company)

_____
(Name of person whose ownership is reported)

_____
(Business address of such person; street, city, zone, state)

Relationship of such person to company named above. (See instruction 5) _____

_____

_____

Date of event which requires the filing of this statement. (See instruction 6) _____

_____

SECURITIES BENEFICIALLY OWNED

TITLE OF SECURITY (See instruction 7)	NATURE OF OWNERSHIP (See instruction 8)	AMOUNT OWNED beneficially (See instruction 9)

REMARKS:
(See instruction 10)

I affirm under penalty of perjury that the foregoing is full, true, and correct.

_____
Signature

Date of Statement _____

FORM A
INSTRUCTIONS

1. PERSONS REQUIRED TO FILE STATEMENTS.

A statement on this form is required to be filed by every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of any equity security of a California stock insurance company, or who is director or an officer of such a company.

2. WHEN STATEMENTS ARE TO BE FILED.

(a) Persons who hold any of the relationships specified in Instruction 1 are required to file a statement within 10 days after assuming such relationship.
(b) Statements are not deemed to have been filed with the Commissioner until they have actually been received by him.

3. WHERE STATEMENTS ARE TO BE FILED.

One signed copy of each statement shall be filed with the Commissioner of Insurance, 600 South Commonwealth Avenue, Los Angeles, CA 90005.

4. SEPARATE STATEMENTS FOR EACH COMPANY.

A separate statement shall be filed with respect to the securities of each company.

5. RELATIONSHIP OF REPORTING PERSON TO COMPANY.

Indicate clearly the relationship of the reporting person to the company; for example, "Director," "Director and Vice President," "Beneficial owner of more than 10 percent of the company's common stock," etc.

6. DATE AS OF WHICH BENEFICIAL OWNERSHIP IS TO BE GIVEN.

The information as to beneficial ownership of securities shall be given as of the date that relationship was assumed.

7. TITLE OF SECURITY.

The statement of the title of a security shall be such as clearly to identify the security even though there may be only one class; for example, "Class A Common Stock," "$6 Convertible Preferred Stock," "5% Debentures Due 1965," etc.

8. NATURE OF OWNERSHIP.

Under "Nature of ownership," state whether ownership of the securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

9. STATEMENT OF AMOUNT OWNED.

In stating the amount of securities beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote, or other appropriate manner, the extent of his interest in the partnership, corporation, trust or other entity.

10. INCLUSION OF ADDITIONAL INFORMATION.

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

11. SIGNATURE.

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specially on his behalf by a person authorized to sign for him.

STATE OF CALIFORNIA

INSURANCE COMMISSIONER

FORM B

STATEMENT OF CHANGES IN BENEFICIAL OWNERSHIP OF SECURITIES

Filed pursuant to Sections 1104.2–1104.8, Insurance Code.

_____

(Name of insurance company)

_____

(Name of person whose ownership is reported)

_____

(Business address of such person; street, city, zone, state)

Relationship of such person to company named above. (See instruction 5)

_____

_____

STATEMENT FOR CALENDAR MONTH OF_____, 19___

CHANGES DURING MONTH AND MONTH-END OWNERSHIP
(See Instruction 6)

TITLE OF SECURITY	DATE OF TRANS-ACTION (See instruc-tion 8)	AMOUNT BOUGHT or otherwise acquired (See instruc-tion 9)	AMOUNT SOLD or otherwise disposed of (See instruc-tion 9)	NATURE OF OWNER-SHIP (See instruc-tion 10)	AMOUNT OWNED beneficially at end of month (See instruc-tion 9)

REMARKS:
(See instruction 11)

I affirm under penalty of perjury that the foregoing is full, true, and correct.

_____

Signature

Date of Statement_____

FORM B
INSTRUCTIONS

1. PERSONS REQUIRED TO FILE STATEMENTS.

Statements on this form are required to be filed by every person who at any time during any calendar month was directly or indirectly the beneficial owner of more than 10 percent of any class of equity security of a California stock insurance company, or a director or officer of the company which is the issuer of such securities, and who during such month had any change in his beneficial ownership of any class of equity security of such company.

2. WHEN STATEMENTS ARE TO BE FILED.

Statements are required to be filed on or before the 10th day after the end of each month in which any change in beneficial ownership has occurred. Statements are not deemed to have been filed with the Commissioner until they have actually been received by him.

3. WHERE STATEMENTS ARE TO BE FILED.

One signed copy of each statement shall be filed with the Commissioner of Insurance, 600 South Commonwealth Avenue, Los Angeles, CA 90005.

4. SEPARATE STATEMENTS FOR EACH COMPANY.

A separate statement shall be filed with respect to the securities of each company.

5. RELATIONSHIP OF REPORTING PERSON TO COMPANY.

Indicate clearly the relationship of the reporting person to the company; for example, "Director," "Director and Vice President," "Beneficial owner of more than 10 percent of the company's common stock," etc.

6. TRANSACTIONS AND HOLDINGS TO BE REPORTED.

Every transaction shall be reported even though purchases and sales during the month are equal or the change involves only the nature of ownership; for example, from direct to indirect ownership. Beneficial ownership at the end of the month of all classes of securities required to be reported shall be shown even though there has been no change during the month in the ownership of securities of one or more classes.

7. TITLE OF SECURITY.

The statement of the title of a security shall be such as clearly to identify the security even though there may be only one class; for example, "Class A Common Stock," "$6 Convertible Preferred Stock," "5% Debentures Due 1965," etc.

8. DATE OF TRANSACTION.

The exact date (month, day and year) of each transaction shall be stated opposite the amount involved in the transaction.

9. STATEMENT OF AMOUNTS OF SECURITIES.

In stating the amount of securities acquired, disposed of or beneficially owned, give the face amount of debt securities or the number of shares or other units of other securities. In the case of securities owned indirectly, i.e., through a partnership, corporation, trust or other entity, the entire amount of securities owned by the partnership, corporation, trust or other entity shall be stated. The person whose ownership is reported may, if he so desires, also indicate in a footnote, or other appropriate manner, the extent of his interest in the transaction or holding of the partnership, corporation, trust or other entity.

10. NATURE OF OWNERSHIP.

Under "Nature of ownership," state whether ownership of the securities is "direct" or "indirect." If the ownership is indirect, i.e., through a partnership, corporation, trust or other entity, indicate, in a footnote or other appropriate manner, the name or identity of the medium through which the securities are indirectly owned. The fact that securities are held in the name of a broker or other nominee does not, of itself, constitute indirect ownership. Securities owned indirectly shall be reported on separate lines from those owned directly and also from those owned through a different type of indirect ownership.

11. CHARACTER OF TRANSACTION.

If the transaction was with the issuer of the securities, so state. If it involved the purchase of securities through the exercise of options, so state and give the exercise price per share. If any other purchase or sale was effected otherwise than in the open market, that fact shall be indicated. If the transaction was not a purchase or sale, indicate its character; for example, gift, 5% stock dividend, etc., as the case may be. The foregoing information may be appropriately set forth in the table or under "Remarks" at the end of the table.

12. INCLUSION OF ADDITIONAL INFORMATION.

A statement may include any additional information or explanation deemed relevant by the person filing the statement.

13. SIGNATURE.

If the statement is filed for a corporation, partnership, trust, etc., the name of the organization shall appear over the signature of the officer or other person authorized to sign the statement. If the statement is filed for an individual, it shall be signed by him or specially on his behalf by a person authorized to sign for him.

NOTE: Authority cited: Sections 1104.2, Insurance Code. Reference: Sections 1104.2–1104.8, Insurance Code.

HISTORY

1. Amendment of Forms A and B filed 11–29–79 as procedural and organizational; effective upon filing (Register 79, No. 48).

§ 2682.4. Ownership of More Than 10 Percent of an Equity Security.

In determining, for the purpose of Section 1104.2 whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, such class shall be deemed to consist of the total amount of such class outstanding, exclusive of any securities of such class held by or for the account of the insurer or a subsidiary of the insurer; except that for the purpose of determining percentage ownership of voting trust certificates or certificates of deposit for equity securities, the class of voting trust certificates or certificates of deposit shall be deemed to consist of the amount of voting trust certificates or certificates of deposit issuable with respect to the total amount of outstanding equity securities of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not all of such outstanding securities have been so deposited. For the purpose of this section a person acting in good faith may rely on the information contained in the latest Convention Form Statement filed with the Insurance Commissioner with respect to the amount of securities of a class outstanding; or in the case of voting trust certificates or certificates of deposit, the amount thereof issuable.

§ 2682.5. Disclaimer of Beneficial Ownership.

Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that such person, is for the purpose of Sections 1104.2 to 1104.8, the beneficial owner of any equity securities covered by the statement.

§ 2682.6. Exemptions from Section 1104.3.

(a) During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from Section 1104.3:

(1) Executors or administrators of the estate of a decedent;

(2) Guardians or committees for an incompetent; and

(3) Receivers, trustees in bankruptcy, assignees for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

(b) After the 12–month period following their appointment or qualification the foregoing persons shall be required to file reports with respect to the securities held by the estate which they administer under Section 1104.2 and shall be liable for profits realized from trading in such securities pursuant to Section 1104.3 only when the estate being administered is a beneficial owner of more than 10 percent of any class of equity security of an insurer subject to Sections 1104.2 to 1104.8.

(c) Securities re–acquired by or for the account of an insurer and held by it for its account shall be exempt from Section 1104.3 during the time they are held by the insurer.

§ 2682.7. Exemption of Securities Purchased or Sold by Odd–Lot Dealers.

Securities purchased or sold by an odd–lot dealer (1) in odd lots so far as reasonably necessary to carry on odd–lot transactions or (2) in round lots to offset odd–lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from Section 1104.3 with respect to participation by such odd–lot dealer in such transactions.

§ 2682.8. Transferable Options, Puts, Calls, Spreads and Straddles.

The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed such a change in the beneficial ownership of the security to which such privilege relates as to be included in the requirement for the filing of a statement reflecting the acquisition or disposition of such privilege set forth in Section 2682.3 hereof. Nothing in this section, however, shall exempt any person from filing the statements required upon the exercise of such option, put, call, spread or straddle.

§ 2682.9. Ownership of Securities Held in Trust.

(a) Beneficial ownership of a security shall include:

(1) the ownership of securities as a trustee where either the trustee or member of his immediate family have a vested interest in the income or corpus of the trust.

(2) the ownership of a vested beneficial interest in trust, and

(3) the ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(b) Except as provided in paragraph (c) hereof, beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of Section 1104.3 where less than twenty percent in market value of the securities having a readily ascertainable market value by such trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from Section 1104.3 with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of such securities by the trust is made without prior approval by the settlor or beneficiary. No exemption pursuant to this subsection shall, however, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of Section 1104.2.

(c) In the event that 10 percent of any class of any equity security of an insurer is held in trust, that trust and the trustees thereof as such shall be deemed a person required to file the reports required by Section 1104.2, and on the forms prescribed by Section 2682.3 hereof, and transactions therein shall be subject to Section 1104.3.

(d) The forms of statements prescribed by Section 2682.3 hereof do not require that more than one report be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or ten percent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or 10 percent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file any such report so long as he relies in good faith upon an understanding that the trustee of such trust will file whatever reports might otherwise be required of such beneficiary.

(e) As used in this section the "immediate family" of a trustee means:

(1) a son or daughter of the trustee, or a descendant of either.

(2) a stepson or stepdaughter of the trustee.

(3) the father or mother of the trustee, or an ancestor or either,

(4) a stepfather or stepmother of the trustee.

(5) a spouse of the trustee.

For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of such person by blood.

(f) In determining, for the purposes of the statements prescribed by Section 2682.3 hereof, whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, the interest of such person in the remainder of a trust shall be excluded from the computation.

(g) No person shall be subject to Section 1104.3, whether or not he is otherwise subject to the reporting requirements of Section 1104.2, with respect to his indirect interest in portfolio securities held by:

(1) a pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan,

(2) a business trust with over 25 beneficiaries.

(h) Nothing in this section shall be deemed to impose any duties or liabilities with respect to any transaction or holding prior to its effective date.

§ 2682.10. Exemptions for Small Transactions.

(a) Any acquisition of securities shall be exempt from Section 1104.3 where

(1) The person effecting the acquisition does not within six months thereafter effect any disposition, otherwise than by way of gift, of securities of the same class, and

(2) The person effecting such acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six months' period during which the acquisition occurs.

(b) any acquisition or disposition of securities by way of gift, where the total amount of such gifts does not exceed $3,000 in market value for any six months' period, shall be exempt from Section 1104.3 and may be excluded from the computations prescribed in paragraph (a) (2).

(c) Any person exempted by paragraph (a) or (b) of this section shall include in the first report otherwise required by Section 1104.2 to be filed by him on the form of statement prescribed by Section 2682.3 hereof, which report is filed after a transaction within the exemption, a statement showing his acquisitions and dispositions for each six month period or portion thereof which has elapsed since his last filing.

§ 2682.11. Exemption from Section 1104.2 of Certain Transactions Exempted from Section 1104.3.

Any transaction which has been or shall be exempted by the foregoing sections hereof from Section 1104.3 shall, insofar as it is otherwise subject to the requirements of Section 1104.2, be likewise exempted from Section 1104.2.

§ 2682.12. Exemption from Section 1104.3 of Certain Transactions Effected in Connection with Distribution.

(a) Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of Section 1104.3 to the extent specified in this section as not comprehended within the purpose of said section, upon the following conditions:

(1) The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of such business, in the distribution of such block of securities;

(2) The security involved in the transaction is

(A) a part of such block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of such block of securities or

(B) a security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over–allotment or other short position created in connection with such distribution; and

(3) Other persons not within the purview of Section 1104.3 are participating in the distribution of such block of securities on terms at least as favorable as those on which such person is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 1104.3 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

(b) The exemption of a transaction pursuant to this section with respect to the participation therein of one party thereto shall not render such transaction exempt with respect to participation of any other party therein unless such other party also meets these conditions of this section.

§ 2682.13. Exemption from Section 1104.3 of Acquisitions of Shares of Stock and Stock Options Under Certain Stock Bonus, Stock Option of Similar Plans.

Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from operation of Section 1104.3 if the plan meets the following conditions:

(a) The plan has been approved, directly or indirectly,

(1) by the affirmative votes of the holders of a majority of the securities of such insurer present, or represented, and entitled to a vote at a meeting duly held in accordance with the applicable laws of this State, or

(2) by the written consent of the holders of a majority of the securities of such insurer entitled to vote: *provided, however,* that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by Article 1, Subchapter 5, Chapter 5, of Title 10 of the California Administrative Code commencing at Section 2680.1, in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by said Article as in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of

(a) the date Sections 1104.2 to 1104.8 first apply to such insurer, or

(b) the acquisition of an equity security for which exemption is claimed. Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with, or mailed for filing to, the Insurance Commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this paragraph, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(b) If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as follows:

(1) With respect to the participation of directors—

(A) by the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

(B) by, or only in accordance with the recommendations of a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

(C) otherwise in accordance with the plan, if the plan

(i) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired and exercised; or

(ii) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

(2) With respect to the participation of officers who are not directors—

(a) by the board of directors of the insurer or a committee of three or more directors; or

(b) by, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons.

For the purpose of this paragraph, a director or committee member shall be deemed to be a disinterested person only if such person is not at the time such discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer of any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(3) The provisions of this paragraph shall not apply with respect to any option granted, or other equity security acquired, prior to the date that Sections 1104.2, 1104.3 and 1104.4 first became applicable with respect to any class of equity securities of any insurer.

(c) As to each participant or as to all participants the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

(d) Unless the context otherwise requires, all terms used in this section shall have the same meaning as in Sections 1104.2 to 1104.8 or elsewhere in these regulations. In addition, the following definitions apply:

(1) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirely at one time.

(2) The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in Sections 422 and 423 of the Inter-

nal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in Section 424 (b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this section, provided, however, that for the purposes of this section an option which meets all of the conditions of that section, other than the date of issuance shall be deemed to be a "restricted stock option."

§ 2682.14. Exemption from Section 1104.3 of Certain Transactions in Which Securities Are Received by Redeeming Other Securities.

Any acquisition of an equity security (other than a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of Section 1104.3 upon condition that

(a) the equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets other than cash (or Government bonds) consist of securities of the insurer issuing the equity security so acquired and which

(1) represented substantially and in practical effect a stated or readily ascertainable amount of such equity security,

(2) had a value which was substantially determined by the value of such equity security, and

(3) conferred upon the holder the right to receive such equity security without the payment of any consideration other than the security redeemed.

(b) no security of the same class as the security redeemed was acquired by the director or officer within six months prior to such redemption;

(c) the insurer issuing the equity security acquired has recognized the applicability of paragraph (a) of this section by appropriate corporate action.

§ 2682.15. Exemption of Long Term Profits Incident to Sales Within Six Months of the Exercise of an Option.

(a) To the extent specified in paragraph (b) of this section, there is hereby exempted, as not comprehended within the purposes of Section 1104.3 any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where such purchase is pursuant to the exercise of an option or similar right either

(1) acquired more than six months before its exercise, or

(2) acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

(b) In respect of transactions specified in paragraph (a) the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of the sale. Nothing in this section shall be deemed to enlarge the amount of profit which would inure to such insurer in the absence of this section.

(c) There is also exempted, as not comprehended within the purposes of Section 1104.3, the disposition of a security, purchased in a transaction specified in paragraph (a) of this section, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in Section 368 (c) of the Internal Revenue Code of 1954, of a person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

(d) The exemptions proved by this section shall not apply to any transaction made unlawful by Section 1104.4 or by any rules and regulations thereunder.

(e) The burden of establishing market price of a security for the purpose of this section shall rest upon the person claiming the exemption.

§ 2682.16. Exemptions from Section 1104.3 of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidation.

(a) The following transactions shall be exempt from the provisions of Section 1104.3 as not comprehended within the purpose of said Section:

(1) the acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(2) The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger of consolidation except, in the case of consolidation, the resulting company;

(3) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidations, computed according to their book values prior to the merger or consolidation as determined by reference to their most recent available financial statements for a 12–month period prior to the merger or consolidation.

(4) The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a 12–month period prior to the merger or consolidation.

(b) A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

(c) Not withstanding the foregoing, if an officer or stockholder shall make any purchase (other than a purchase exempted by this section) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by this section) of a security in any other company involved in the merger or consolidation within any period of less than six months during which the merger or consolidation took place, the exemption provided by this section shall be unavailable to such officer, director, or stockholder.

§ 2682.17. Exemption from Section 1104.3 of Certain Securities Received upon Surrender of Similar Equity Securities.

Any receipt by a person from an insurer of shares of stock of a class having general voting power, upon the surrender by such person of an equal number of shares of stock of the insurer of a class which does not have general voting power pursuant to provisions of the insurer's certificate of incorporation, for the purpose of and accompanied simultaneously or followed immediately by the sale of the shares so received, shall be exempt from the operation of Section 1104.3 as a transaction not comprehended within the purpose of said section, if the following conditions exist:

(a) The person so receiving such shares is not an officer or director, or the beneficial owner, directly or indirectly, immediately prior to such receipt, of more than 10 percent of an equity security of the insurer;

(b) The shares surrendered and the shares issued upon such surrender shall be classes which are freely transferable and entitle the holders thereof to participate equally per share in all distribution of earnings and assets;

(c) The surrender and issuance are made pursuant to provisions of a certificate of incorporation which require that the shares issued upon such surrender shall be registered upon issuance in the name of a person or persons other than the holder of the shares surrendered and may be required to be issued as of right only in connection with the public offering,

sale and distribution of such shares and the immediate sale by such holder of such shares for that purpose, or in connection with a gift of such shares.

(d) Neither the shares so surrendered nor any shares of the same class, nor other shares of the same class as those issued upon such surrender, have been or are purchased (otherwise than in a transaction exempted by this section), by the person surrendering such shares, within six months before or after such surrender or issuance.

§ 2682.18. Exemption from Section 1104.3 of Certain Transactions Involving an Exchange of Similar Securities.

Any acquisition or disposition of securities made in an exchange of shares of a class (or series thereof) of stock of an insurer for an equivalent number of shares of another class (or series thereof) of stock of the same insurer, pursuant to a right of conversion under the terms of the insurer's charter or other governing instruments shall be exempt from the operation of Section 1104.3 if—

(1) The shares surrendered and those acquired in exchange therefor evidence substantially the same rights and privileges except that, pursuant to the provisions of the insurer's charter of other governing instruments, the board of directors may declare and pay a lesser dividend per share on shares of the class surrendered than on shares of the class acquired in exchange therefor, or may declare and pay no dividend on shares of the class surrendered; and

(2) The transaction was effected in contemplation of a public sale of the shares acquired in the exchange; *provided* that this section shall not be construed to exempt from the operation of Section 1104.3 any purchase or sale of shares of the class surrendered and any sale or purchase of shares of the class acquired in the exchange (otherwise than in the transaction of exchange exempted by this section) within a period of less than six months.

§ 2682.19. Exemption of Certain Transactions by a Dealer in Securities in Which He Has No Interest.

Transactions in any security shall be exempt from the operation of Section 1104.4 to the extent necessary to render lawful under such section the execution by a broker of an order for an account in which he has no direct or indirect interest.

§ 2682.20. Exemption from Section 1104.4 of Certain Transactions Effected in Connection with a Distribution.

Any security shall be exempt from the operation of Section 1104.4 to the extent necessary to render lawful under such section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

(a) The sale is represented by an over–allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting–dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

(b) Other persons not within the purview of Section 1104.4 are participating in the distribution of such block of securities on terms at least as favorable as those on which such dealer is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of Section 1104.4 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

§ 2682.21. Exemption from Section 1104.4 of Sales of Securities to be Acquired.

(a) Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of Section 1104.4. provided that:

(1) the sale is made subject to the same conditions as those attaching to the right of acquisition, and

(2) such person exercises reasonable diligence to deliver such security to the purchaser promptly after his right of acquisition matures, and

(3) such person reports the sale on the appropriate form for reporting transactions by persons subject to Section 1104.2.

(b) This section shall not be construed as exempting transactions involving a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when–issued" or "when–distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition.

§ 2682.22. Arbitrage Transactions Under Section 2682.7.

It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of such insurer, unless he shall include such transaction in the statements required by Section 1104.2 and shall account to such insurer for the profits arising from such transaction, as provided in Section 1104.3. The provisions of Section 1104.4 shall not apply to such arbitrage transactions. The provisions of Section 1104.2 to 1104.8 shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than such director or officer of the insurer.

Article 3. Insurance Holding Company Systems—Reporting and Disclosure Forms

§ 2683. Authority.

These regulations are promulgated pursuant to the authority granted the Insurance Commissioner by the Insurance Holding Company System Regulatory Act (sometimes referred to herein as "the Act," "said Act" or "said Article 4.7"), Chapter 1275, Statutes of 1969, now Insurance Code Sections 1215 through 1215.14, which becomes effective November 10, 1969. Reference herein to said Act are to the same as it now exists or may hereafter be amended.

NOTE: Authority cited for Article 3 (Sections 2683 through 2683.15): Sec. 1215.8 Insurance Code.

HISTORY

1. New Article 3 (Sections 2683 through 2683.15) filed 12–18–9 as an emergency; designated effective 12–22–69 (Register 69, No. 15).
2. Certificate of Compliance —Sec. 11422.1, Gov. C. filed 3–20–70 (Register 70, No. 12).
3. Amendment of Article 3 (Sections 2683 through 2683.23) filed 3–20–70; effective thirtieth day thereafter (Register 70, No. 12).

§ 2683.1. Purpose.

The purpose of these regulations are: to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the Act. The information called for by these regulations is hereby declared to be necessary and appropriate in the public interest and for the protection of policy holders and shareholders in this State. These regulations shall not curtail or contravene any statute.

§ 2683.2. Severability Clause.

If any provisions of these regulations, or the application thereof to any person or circumstances, is held invalid, such invalidity shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

§ 2683.3. Reporting to Be in English Language; Financial Statements in U.S. of A. Dollars and Cents.

The forms and any exhibits filed pursuant to these regulations shall be in the English language. Any exhibit submitted in a foreign language

shall be accompanied by an accurate translation into English. Monetary value shown on all forms and exhibits shall be stated in dollars and cents of the United States of America monetary system.

§ 2683.4. Definitions.

(a) "Executive officer" means any individual charged with active management and control in an executive capacity (including a president, vice president, treasurer, secretary, controller, or other individual performing like functions) of the person registering, reporting or filing under these regulations, whether such reporting person is incorporated or unincorporated.

(b) "Ultimate controlling person" means that controlling person within an insurance holding company system, which controlling person is not controlled by any other person.

(c) Unless the context otherwise requires, other terms found in these regulations and in Section 1215 of the Insurance Code are used as defined in last said section. Other nomenclature or terminology is according to the Insurance Code, or industry usage if not defined by the Code.

§ 2683.5. Letter of Transmittal.

Each form or amendment filed pursuant to these regulations shall be accompanied by a letter of transmittal which letter shall include a statement of the name, title, address and telephone number of the individual to whom communications concerning the paper filed should be addressed.

§ 2683.6. Forms—In General.

(a) The forms set forth in these regulations are intended as a guide in determining and preparing the information to be supplied and the order in which it is to be listed.

(b) Any form set forth in these regulations may be reproduced at the user's discretion so as to provide additional space after item as may be needed for entry of information thereon. Information that is capable of being stated briefly may be filled out on the form. Other required information which must be specially prepared should be presented on separate exhibits identified and referred to in the appropriate place or places on the form being filed. Such a specially prepared exhibit need not repeat the language of the item on the form in response to which it is supplied, but the exhibit should be captioned with reference to the form, the numbered item on the form and the nature of the information contained in the exhibit.

(c) Papers filed shall normally be limited to 8 1/2″ x 13″ in size and preferably bound at the top. National Association of Insurance Commissioners convention form annual statements may be furnished in their full size, but any such applicable current statements already on file may be incorporated by reference. The instructions contained in subdivision (b) of this section pertaining to special exhibits likewise apply. Each such completed filing shall either be captioned with reference to the appropriate Department form or shall otherwise be clearly labeled as to its nature.

(d) Every filing, report, or request made pursuant to these regulations shall state on the face page thereof the names and addresses of all persons on whose behalf the same is made and filed.

§ 2683.7. Incorporation by Reference.

(a) Except as otherwise provided in this section, a person making any report, request, or filing required by the Act may incorporate therein by reference any required then current appropriate information already on file with the Commissioner, or any diagram or chart previously filed. In such event, the person filing shall cause the paper filed to identify the report, statement, document, instrument, diagram, chart or other paper to which reference is made, the approximate date it was filed with the Commissioner, and the page or pages thereof wherein is shown the information incorporated by reference.

(b) Subdivision (a) above shall not apply to the Information Statement and accompanying papers (see Form A) reburied by Insurance Code Section 1215.2 of the Act and these regulations in connection with a tender offer, an offer of acquisition and the like. Such Information Statements shall be complete in themselves.

(c) Whenever any action authorized to be taken by the commissioner under said Act may be done only after notice and hearing, all information required by the Act and these regulations to be filed in connection with such action by the Commissioner shall be provided in full without incorporation by reference.

(d) In the event that a finding or determination or any action made or taken by the Commissioner pursuant to the Act appears to be the probable subject of judicial review, the admitted insurer or person making the filing on the basis of which such finding or determination was made or such action is to be taken shall, at the Commissioner's request, file the required information in full without incorporation by reference.

§ 2683.8. Who Must Register.

Except as in this section otherwise provided, the following described admitted insurers are required to register pursuant to Section 1215.4 of the Act and these regulations, and to maintain their registration in a current state:

(a) Every admitted domestic insurer which is a member of an insurance holding company system, i.e., generally one which owns or controls one or more subsidiaries (insurers or not), or is owned or controlled by, or is under common control with, another person; and

(b) Every admitted foreign insurer which is a member of an insurance holding company system and whose domiciliary state does not have statutory or regulatory disclosure requirements and standards substantially similar to those contained in Section 1215.4 of the Insurance Code.

§ 2683.9. Special Provisions for Individual Person Affiliates.

(a) An individual person who directly or indirectly owns or exercises voting control or more than ten percent of the voting securities of any member of an insurance holding company system may either:

(1) File a disclaimer in conformity with Insurance Code Section 1215.4 (i) and these regulations, if in fact such individual person's ownership of securities or exercise of voting power does not in the particular case result in effective control of the other member; or

(2) If such a person's ownership of securities or exercise of voting power does in fact result in control of the other member, such individual may file an abbreviated registration statement as hereinafter provided in this section.

(b) An individual person who, according to law (Insurance Code Section 1215 (a), (b), (c) and (d)), is a member of an insurance holding company system shall be required to register pursuant to Section 1215.4 (a) of the Insurance Code under the same circumstances as other "persons" are. Such an individual need file only the following in his registration statement, certified under penalty of perjury as being true and correct in relation to all matters which are or reasonably should be within his personal knowledge, and true and correct according to his information and belief (stating the source of his information) as to any other matters:

(1) The name and address of the other member or members of the insurance holding company system whose securities he owns or has the authority to vote, and the amount or number of each kind of voting securities (describing the same) which he holds or votes, and the approximate percentage of the insurer's outstanding voting securities which his holdings, including shares he is authorized to vote, represent;

(2) When and from whom such voting authority (e.g., proxies) and/or shares were acquired, whether such shares were acquired at the then market price, and whether they are presently hypothecated;

(3) Whether the registrant (individual) is under contract to or has an understanding with any other person to vote any of such shares as directed by such other person;

(4) Registrant's own name, address, and the names and addresses of all insurers with whom he is now or has been affiliated, employed by, or served as officer or director of during the ten years last preceding;

(5) Whether registrant has been convicted, or had sentence imposed, suspended, or been pardoned for conviction of, or pleaded guilty to or

nolo contendere to, an information or indictment charging a felon for any of the following: theft or larceny; mail fraud; violation of any state or federal corporate securities law or insurance law; also, whether he has been the subject of a cease and desist order by any state or federal securities regulatory agency. In any instance where the answer is affirmative, identify the court or agency, nature of the action or proceeding, give case or file number, the place, date, and summarize the facts, including final disposition;

(6) Whether affiant has been an officer, director, trustee, general manager, investment committee member or controlling stockholder of an insurer which, while he occupied such position or within one year thereafter, was taken into conservatorship, declared insolvent; or while he occupied such position was enjoined from violating or ordered to cease and desist from violating any securities or insurance law, or whose license or certificate of authority as an insurer was revoked or suspended for a like cause.If any answer is affirmative, explain fully, giving names, places, dates, circumstances and ultimate disposition.

(7) Such other information as the Commissioner may reasonably deem necessary.

(c) Except as above set forth the requirements of Insurance Code Section 1215.4 (b) are deemed inapplicable to individual person affiliates as not comprehended within the purpose of said Section 1215.4.

§ 2683.10. When to Register.

Every insurer subject to registration pursuant to Insurance Code Section 1215.4 shall register within 15 days after it becomes subject to these requirements, unless the Commissioner for good cause shown extends the time for registration.

§ 2683.11. Where and How to File Registration Statement.

(a) Each registration statement and accompanying exhibits filed pursuant to the Act and these regulations may be filed by delivering or mailing a single copy to the Insurance Commissioner of the State of California, Attention of Company Information and Analysis Division, at the Commissioner's office in San Francisco, California.

(b) The information supplied shall be current according to the company's (or the individual's, as appropriate) most recent records. Where underwriting information and surplus condition is not reflected in the latest quarterly statement, an accurate interpolation may be used. Indicate figures arrived at by interpolation.)

§ 2683.12. Consolidated Registrations.

Two or more affiliated insurers subject to registration under the Act may, unless the Commissioner directs otherwise, file a consolidated registration statement and consolidated supplements or reports amending their consolidated registration or their individual registration statement. In any such case the statement or supplement filed shall clearly identify all constituents or affiliates, and the Commissioner may require a separate statement of the assets and liabilities of each.

§ 2683.13. Substituted Registration.

When two or more admitted insurers of an insurance holding company system are subject to registration under said Act, and one of them is organized under the laws of this State, the domestic insurer may, if a consolidated registration is not made, file its own registration statement and that of any of its affiliates subject to registration hereunder.

§ 2683.14. Notification by Foreign Insurer of Registration In Its State of Domicile; Discontinance.

(a) If the state of domicile of an admitted insurer subject to Section 2683.8 (b) applies statutory or regulatory registration and disclosure requirements substantially similar to those of this State, and such insurer files its initial registration statement in accordance with its domiciliary state's requirements, or such registration statement has been filed on its behalf, the insurer shall notify the Commissioner in writing of such fact and of the date such filing was made, by whom, and where. Said communication may contain a statement to the effect that the insurer by virtue of such filing considers itself not subject to California Insurance Code Section 1215.4 (a).

(b) Whenever any admitted former member of an insurance holding company system ceases to be a member thereof, it shall promptly notify the Commissioner.

§ 2683.15. Registration Statements of Nonadmitted Members of a Holding Company System.

In the event the Commissioner requires copies of the registration statements or other information filed by members of a holding company system with their domiciliary insurance regulatory authorities, which members are not prima facie subject to registration under Insurance Code Section 1215.4 (a), such copies shall be provided and filed by an admitted insurer of the system. Said copies may be conformed copies but shall be certified to by an executive officer of the filing (admitted) insurer as being a full, true and correct copy of the registration statement or other information filed with the aforementioned domiciliary insurance regulatory authority or authorities.

§ 2683.16. Annual Supplements and Reporting of Material Changes; Dividends.

(a) Annual supplements to its original registration or a complete new registration statement (as the filing registrant may find more suitable or convenient) shall be filed by or on behalf of each registrant subject to these registration provisions within 120 days after the end of the filing registrant's fiscal year. Such supplement shall report any material changes in the information required to be shown in a registration statement hereunder, which changes are not clearly reflected in the insurer's annual statement filed each March 1st with the Commissioner.

(b) Each registrant shall keep current the information required to be shown in its original registration statement by reporting all material changes or additions. Such amendments, consecutively numbered, shall be filed within 15 days after the end of the calendar month in which the registrant learns of each such material change or addition.

(c) Notwithstanding the foregoing, each registrant shall report on all dividends (including regular dividends) and other distributions to shareholders promptly upon the declaration thereof. (But see Section 2683.23 (b), infra.)

§ 2683.17. Registration—How and When Terminated.

Ten days after receipt by the Commissioner, absent notice to the contrary, of a written verified statement which may be in letter form, containing satisfactory proof that a registrant is no longer a member of an insurance holding company system, such registrant's registration shall be deemed terminated and it shall no longer be subject to the obligations of registering and keeping current its registration hereunder, unless and until it again becomes subject to registration under said Act.

§ 2683.18. Information Statement—Offer of Acquisition.

(a) No tender offer for, or request or invitation for tenders of, and no agreement shall be made to exchange securities for, or to acquire in the open market, any voting security or any security convertible into a voting security of a domestic insurer or of any other person controlling a domestic insurer under the circumstances described in (1) and (2) of this subdivision, unless the conditions set forth in subdivision (b) of this section are complied with.

(1) The circumstances alluded to in (a) above are that as a result of the consummation of such offer, the Offeror would directly or indirectly acquire control of the domestic insurer; and

(2) The "other person" controlling the domestic insurer whom the offer will affect is not substantially engaged in non–insurance businesses either directly or through its affiliates.

(b) No offer, request, initiation or agreement described in (a) of this section shall be made or entered into unless, at the time such is done, the following conditions are met:

(1) Not later than the date when copies of the offer of purchase or request or invitation are first published or sent or given to holders of the securities sought to be obtained, or the agreement or transaction is entered

into, the Offeror shall file with the Commissioner and shall have transmitted to the said domestic insurer a statement containing the information specified by Form A hereinafter set forth in these regulations.

(c) Copies of any additional material soliciting or requesting such tender offers subsequent to the original solicitation on request, and copies of any amendments to any such agreement changing any of the information therein required shall be filed in complete up–to–date form and content with the Commissioner and sent to such insurer not later than the time copies of such material are first published or sent or given to security holders or immediately after such amendment is entered into.

(d) If the offer, invitation or agreement described therein is proposed to be made by means of a registration statement under the Federal Securities Act of 1933, or in circumstances requiring the disclosure of similar and equivalent information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or equivalent disclosure, the Offeror (or person required by Insurance Code Section 1215.2 (a) to file this statement) may file that registration statement with the Commissioner in lieu of this Information Statement and may send or give the same to the security holders being solicited in this State in full satisfaction of the requirements hereof. The burden is on any Offeror (or other person so required to file) relying on a disclosure pursuant to a state law to show that the disclosure requirements under it are similar and equivalent to those of the California law.

(e) If the person required to file this statement is a partnership, limited partnership, syndicate or other group, the information called for in Items II, III, IV, V, VII, and VIII hereinafter shall be furnished with respect to: (a) each partner ; (b) each member of such syndicate or group; and (c) each person who controls such partner or member (control of more than ten percent of its outstanding voting securities, by proxy or otherwise, results in "control" of such a person).

(f) If a person referred to in subdivision (e) above is a corporation, the information called for by said Paragraphs II, III, IV, V, VII, and VIII hereinafter shall be furnished to the extent applicable with respect to such corporation and each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of such corporation.

(g) No transaction shall be consummated until the Commissioner either approves the same within 60 days after the Information Statement herein required shall have been filed with him, or until he fails to disapprove same within such 60–day period. Grounds for disapproval are as prescribed by statute. Any disapproval shall be in writing stating the reasons therefore.

§ 2683.19. Extraordinary Dividends and Distributions.

(a) Requests pursuant to the provisions of Insurance Code Section 1215.5 (c) for approval of extraordinary dividends or extraordinary distributions (hereinafter in this Section referred to as "dividend(s)") to stockholders shall include the following:

(1) The amount and date established for payment thereof;

(2) A statement whether payment is to be in cash or property, and if in property, the fair market value of that property, and an explanation of the valuation basis.

(3) The amounts and dates of all dividends (including regular dividends) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year.

(4) A balance sheet and statement of income for the period intervening between the end of the year covered in the last annual statement filed with the Commissioner and the end of the last calendar quarter prior to the date on which the request for approval is filed with him, plus such additional financial information, if any, as the Commissioner may require.

(5) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and reasonableness of its remaining surplus in relationship to its outstanding liabilities, and upon the adequacy of its remaining surplus in relationship to its financial needs.

(b) The payment of an extraordinary dividend, as defined in Insurance Code Section 1215.5 (c), by a company which is qualified according to Section 1215.1 (b) (2) ibid., both before and after payment thereof is deemed automatically approved. The registrant shall give written notice (by letter) to the Commissioner of the declaration thereof, pursuant to Section 1215.4 (d) ibid.

§ 2683.20. Disclaimers.

(a) Any person filing a disclaimer as permitted by Insurance Code Section 1215.4 (i) may use either Form D or Form DD to the extent that the form selected accommodates recitation of the facts by virtue of which affiliation with any authorized (admitted) insurer is disclaimed. In the event neither form is reasonably appropriate, the person wishing to disclaim affiliation may file a written disclaimer duly executed by its (or his) executive officer in any other form that supplies the information required in such instance by said Section 1215.4 (i).

(b) In the event several persons of a holding company system wish to disclaim affiliation with anther person or persons, a single disclaimer may be filed for the several disclaiming persons under the following circumstances:

(1) The persons with whom relationship is disclaimed are identical in the case of every person on whose behalf the disclaimer is filed; and

(2) The facts on which disclaimer is based are substantially identical with respect to each such disclaiming person; and

(3) The disclaimer is executed by an executive officer of the ultimate controlling person or of an admitted insurer, which officer knows the facts of his own knowledge.

§ 2683.21. Additional Information.

Each person filing under these regulations shall, in addition to the information called for by the regulations and instructions, furnish any other or further information and material as may be needed to make the information otherwise to be contained in such filing not misleading.

§ 2683.22. Verification of Forms Required.

(a) Information statements, registration statements, annual supplements, reports of extraordinary dividends and distributions, reports of material changes, and disclaimers all shall be verified as follows:

(1) Those executed by domestic insurers shall be verified as provided in the Code of Civil Procedure for the verification of pleadings (Sections 446 and 2015.5 CCP); the same shall apply to such papers executed in a jurisdiction whose law on the subject of verification of pleadings is the same as that of this State.

(2) Otherwise, such papers shall be duly sworn to under oath before a public officer lawfully authorized to administer oaths, and his certificate evidencing such fact shall be attached thereto;

(b) Reports of declaration of regular dividends may be in unverified letter form by an executive officer of the declarant or the filing member who knows the facts. A single such report may be made for all members of an insurance holding company system provided the officer making the same knows the facts. However, each member reported for must be listed by name and the amount of its dividend separately stated.

(c) An acceptable form of California verification is:

"State of California
County of San Mateo } ss

John Smith, the undersigned, hereby certifies under penalty of perjury that he is the President of ABC Insurance Company, registrant in the foregoing registration statement; that he has read the said registration statement and knows the contents thereof and that the same are true of his own knowledge.

Dated this _____ day of_____ 19___, at Redwood City, California.

/S/ John Smith

/T/ John Smith President"

An acceptable form of verification by a foreign applicant is as follows:

"State of Illinois } ss
County of Cook }

John Smith, first being duly sworn, deposes and says that he is the President of ABC Insurance Company, the person preparing and filing the attached paper (s); that he has read the same and knows the contents thereof and that the contents are true of his own knowledge.

/S/ John Smith

/T/ John Smith President

Subscribed and sworn to before me this
_____day of_____, 19____.
_____ (Notarial Seal)
Notary Public in and for said County
and State
My commission expires _____"

The examples set forth above do not forbid verification of certain allegations on the basis of affiant's information and belief where that is permissible according to law.

(d) In the case of papers described in (a) of this section filed by foreign insurers they shall be verified (except as provided in (b) above) according to the applicable law and regulations of the place where the same were signed by the executive officer of the person making the filing.

HISTORY

1. Editorial correction of subsection (c) (Register 95, No. 42).

§ 2683.23. Promulgated Forms.

Various forms which said Act requires the Commissioner to prescribe, and others deemed necessary or convenient for accomplishing registration, reporting, disclosure and other portions of the Act which require implementations, are set forth in this section as follows:

FORM A (3–20–70)

To: The Insurance Commissioner of the State of California
Attention: Surveillance and analysis Division
600 South Commonwealth Avenue—14th Floor
Los Angeles, CA 90005

INFORMATION STATEMENT
of

_____
(Name and address of Offeror)

_____
concerning an offer to acquire control of _____

_____
an insurer (as defined by California Insurance Code Section 826, excluding subdivision (f) thereof) organized under the laws of the State of California.

The above–captioned contemplated transaction involves an offer to acquire voting securities of the above–named domestic insurer of such controlling corporation through the means of a _____

_____
(Explain, e.g.: purchase on open market, exchange of holding company shares, creation of new corporation and exchange of holding company shares, creation of new corporation and exchange, etc.)

Filed pursuant to Insurance Code Section 1215.2 and Sections 2683, et seq., Title 10, California Administrative Code.

The undersigned hereby states as follows:

ITEM I

The Offer to Purchase or Exchange Shares, or the Agreement of Merger or Plan of Reorganization

1. True copies of the written offer, agreement, or plan, complete with proxy, proxy statement, letter to stockholders, letter of transmittal, tender forms, fractional buy and sell order forms, etc., are attached hereto marked _____.

ITEM II

Identity and Background of the Offeror (Section 1215.2 (a)(1))

(a) State the name and address of the Offeror seeking to acquire control over the insurer.

(b) If the Offeror is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the Offeror and the Offeror's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of, and interrelationships (including the percentage of each class of voting securities) among the Offeror and all persons known to control the Offeror. If control is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart, indicate the type of organization (e.g.—corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings looking toward a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the location and title of the court, nature of the proceedings, and the date when commenced.

ITEM III

Identity and Background of Individuals Associated with Offeror (Section 1215.2 (a) (1)

State the following with respect to

(a) the Offeror if he is an individual or

(2) all persons who are directors, executive officers, or owners of ten percent of more of the voting securities of the Offeror if the Offeror is not an individual:

(a) Name and business address;

(b) Present principal business activity, occupation or employment, including positions and offices held, and the name, principal business and address of any corporation or other organization by which such person or persons are employed;

(c) Major occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; and if any such occupation, position, office or employment was carried on; and if any such occupation, position, office or employment required licensing by or registration with any federal, state, county or municipal government agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

(d) Whether such person has during the last ten years been convicted in a criminal proceeding (excluding minor traffic violations) If so, give the date, nature of the offense for which convicted, name and location of the court, penalty imposed, or other disposition of the case.

ITEM IV

Nature, Source and Amount of Consideration (Section 1215.2 (a) (2))

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the purchase, exchange, merger or other acquisition of control.

If any part of the funds or other consideration has been or is to be borrowed or otherwise obtained for the purpose of making the purchase, or effecting the exchange, merger, or other acquisition of control, furnish a description of the transaction, the names of the parties thereto, the relationship if any between the borrower and the lender, the amounts to be borrowed from each, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) An explanation of the criterion or criteria used in determining the value of any consideration to be used other than money.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the Offeror wishes the source to remain confidential, he must specifically request that the identity of the source be kept confidential.

(d) If the consideration is to consist in whole or part of the insurance business and assets of the Offeree or of a person controlled by the Offeree, state the value thereof and how such value was arrived at. The Commissioner may request a valuation by a qualified actuary.

ITEM V

Future Plans for Insurer (Section 1215.2 (a) (3))

1. Describe any plans or proposals which the Offeror may have to liquidate such insurer, to sell its assets to or merge it with any person, or to make any other major change in its business operations of corporate structure or management.

2. Explain fully all phases of any merger, acquisition or reorganization.

3. Compare the financial and legal position, equities, rights and relationships of the Offeree(s) (individual, corporation or stockholder, as applicable) before or after consummation of the proposal, assuming it will be effectuated.

4. Describe all changes planned to be made after consummation of the acquisition with respect to personnel comprising the board of directors and executive officers of the domestic insurer sought to be acquired, or those of the organization which will succeed the latter as a result of the acquisition, as appropriate. State the nature, extent and amount of any commitments to the present officers and directors of the domestic insurer. Attach copies of all actual or contemplated employment contracts, contracts for consultation, advice, management or services.

ITEM VI

Voting Securities to be Acquired

State the number of shares of the insurer's voting securities which the Offeror, its affiliates and any person listed in Item III plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement of the method by which the Offeror arrived at the value assigned to the securities sought to be acquired.

ITEM VII

Ownership of Voting Securities (Section 1215.2 (a) (4))

State the amount of each class of voting securities or securities which may be converted into voting securities of such insurer or such controlling person which are beneficially owned or concerning which there is a right to acquire beneficial ownership by the Offeror, its affiliates or any person listed in Item II above, together with the name and address of each such affiliate.

ITEM VIII

Contracts, Agreements, or Understandings with Respect to Voting Securities of the Insurer (Section 1215.2 (a) (5))

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which Offeror, its affiliates or any person listed in Item III above are involved, including but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Name and identify the person with whom such contracts arrangements or understandings have been entered into.

ITEM IX

Recent Purchases of Voting Securities

Describe all purchases by the Offeror, its affiliates or any person listed in Item III of any voting securities of the insurer during the 12 calendar months preceding the filing of this Statement. State the number of shares acquired in each transaction, the dates of purchase, names of the purchasers, and the consideration paid or agreed to be paid thereof. State whether any such shares so purchased are hypothecated.

ITEM X

Recent Recommendations to Purchase

Describe all recommendations made by Offeror or anyone in its behalf during the 12 calendar months preceding the filing of this Statement to purchase any voting security of the insurer control of which is sought to be acquired.

ITEM XI

Agreements with Broker–Dealers

Describe the terms of or attach a copy of any agreement, contract or understanding made with any broker–dealer as to solicitation of voting securities of the insurer for tender, and the amount of any fees, commissions or other commissions or other compensation to be paid to broker–dealers with regards thereto.

ITEM XII

Financial Statements and Exhibits

(a) Offeror's annual financial statements for the last five years and annual Reports to Stockholders for the last two fiscal years, plus any in the process of distribution by Offeror to its stockholders, shall be attached to this statement as exhibits; listed under this item the exhibits so attached.

(b) The financial statements shall contain accurate financial information as to the earnings and financial condition of the Offeror and its affiliates for the preceding five fiscal years (or for such lesser period as such affiliate and any predecessors thereof shall have been in existence), and similar information as of a date not earlier than 90 days prior to the filing of the information statement.

IN WITNESS WHEREOF the person making and filing this information statement hereby incorporates herein all exhibits attached hereto and all writings referred to herein, and declares that the matters stated herein and in the attached exhibits and in the writings incorporated herein are true and correct. In witness whereof the Offeror hereunto affixes its (or his) signature and seal at_____this_____day of_____, 19___.

_____

(Exact name of Offeror or other person filing)

(ATTACH VERIFICATION)

By_____

(Refer to Section 2683.22) (Name and title of officer executing)

FORM B (3–20–70)

To State of California Insurance Commissioner:

INSURANCE HOLDING COMPANY SYSTEM

REGISTRATION STATEMENT Of ..... (State name of the ultimate controlling person) and .... (Name above all California domestic insurer members of the holding company system) and .... (Name above all admitted foreign insurer members of the holding company system)	(Mark one☒) INITIAL REGISTRATION STATEMENT ☐ AMENDMENT NUMBER..... ☐ ANNUAL SUPPLEMENT FOR YEAR ..... TO INITIAL REGISTRATION STATEMENT ☐ ..... (Department Use Only) FILED: .....

The above named Registrant(s) hereby report(s) to the Insurance Commissioner for the purpose of registering as required by California Insurance Code Section 1215.4 as follows:

ITEM I

Identity and Control of Registrant

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"); the domiciliary address and the

principal office address of each; the date on which each Registrant became part of the insurance holding company system; and the method (s) by which control of each Registrant was acquired and is maintained.

ITEM II

Organizational Chart

Furnish a chart or listing clearly presenting the identities of and interrelationships (including the percentage of each class of voting securities) among the Registrant and all affiliated persons known to control the Registrant. If control is maintained other than by the ownership or control of voting securities, indicate the basis of such control.

ITEM III

The Ultimate Controlling Person

As to the ultimate controlling person, furnish the following information:

(a) Name.

(b) Address of principal office.

(c) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

(d) The principal business of said person.

(e) The name and address of any person who holds 10 percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(f) If court proceedings looking toward a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM IV

Biographical Information

Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

ITEM V

Transactions, Relationships and Agreements

(a) Briefly describe the following agreements in force, relationships subsisting, and transactions currently outstanding between the Registrant and its affiliates;

(1) loans, other investments, or pending purchases, sales or exchanges of securities of its affiliates by the Registrant or of the Registrant by any of its affiliates;

(2) other purchases, sales or exchanges of assets uncompleted or being negotiated;

(3) transactions not in the ordinary course of business;

(4) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) all management and service contracts and all cost–sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principals; and

(6) reinsurance agreements, whether already in force or entered into but not yet effective, covering all or substantially all of one or more lines of insurance of the ceding company.

No information need be disclosed if such information is not material. Sales, purchases, exchanges, loans or extensions of credit or investments involving one–half of one percent or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner so as to enable proper evaluation thereof by the Commissioner and shall include at least the following: the nature and purpose of the transaction; the nature and amounts of any payments or transfers of assets between the parties; and the identity of all parties to such transactions.

ITEM VI

Litigation or Administrative Proceedings

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which any person reporting herewith or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; given the names of the parties and the court or agency in which such litigation or proceeding is or was pending.

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of any admitted insurer member of the holding company system including, but not necessarily limited to, bankruptcy, receivership, other corporate reorganizations, and litigation drawing in question the validity of the issued and outstanding shares of any such admitted or nonadmitted insurer member, or of the ultimate controlling person.

ITEM VII

Financial Statements and Exhibits

(a) Financial statements and exhibits of each person reporting herewith should be attached to this Statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include a balance sheet of the ultimate controlling person as of the end of such person's latest completed fiscal year ended 120 days or more prior to the filing of this form in California and related statements of income and surplus for the year then ended, and for any subsequent period for which such financial and related statements are available. in lieu of an individual statement, Registrant may, unless the Commissioner requires otherwise, furnish a certified consolidated financial statement for the ultimate controlling person prepared in its usual course of business.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and any proxy solicitation material distributed by it during the preceding year or prepared for current use.

The undersigned hereby incorporates in this report any and all addenda, contracts, treaties, or exhibits attached hereto or incorporated herein by reference, and declares that the same are true, and are correctly represented as currently in force.

IN WITNESS WHEREOF, the undersigned registrant hereby affixes its name and corporate seal this_____day of_____, 19____at_____ in the State of_____

_____
Name of Company

By _____
(President or Vice President)

(CORPORATE SEAL)

By _____
(Secretary or Treasurer)

(Attach verification)(See Section 2683.22).

FORM C (3–20–70)

To: The Insurance Commissioner of the State of California

Amendment to Registration Statement of _____ | FILED _____

The above named Registrant hereby makes and files this amendment No. _____ as provided by California Insurance Code Section 1215.4(d), to its registration statement heretofore filed on or about _____ (date) with the California Insurance Commissioner pursuant to Section 1215.4(a) of the Insurance Code.

Changes in or additions to the matters set forth in registrant's last prior registration statement or such statement as amended have occurred, or dividends and other distributions to shareholders have been made as follows:

The undersigned hereby incorporates in this report any and all addenda, contracts, treaties, or exhibits attached hereto and by this reference incorporates them herein. Registrant declares that the same are true, and are correctly represented as currently in force.

IN WITNESS WHEREOF, the undersigned Registrant hereby affixes its name and corporate seal this _____ day of _____, 19 ____, at _____ in the State of _____

_____
Name of company

By _____

(CORPORATE SEAL) (Position or title. Must be an executive officer.)

FORM D (3–20–70)

To: The Insurance Commissioner of the State of California

DISCLAIMER (Insurance Code Section 1216.4(i))

by _____

_____

_____

of affiliation with

_____

_____

_____

_____

Dated _____, 19 _____ at _____

The undersigned hereby alleges:

1. It does not directly, or indirectly through one ore more subsidiaries, control (within the meaning of California Insurance Code Section 1215 (b))

_____
(Name of the admitted insurer with whom affiliation is disclaimed)

of _____
(Give domiciliary city and state)

2. It is not directly or indirectly (through one or more subsidiaries) controlled by or under common control with the last above-named insurer.

3. Insofar as known to the undersigned, all material relationships and bases for asserted affiliation between the undersigned and said insurer are:

(a) The total number of authorized, issued and outstanding voting securities of said insurer is _____

(b) Of such number of shares, the undersigned own or control the voting rights (by proxy or otherwise) of _____ shares, or approximately _____ % of the total number of issued and outstanding shares of said insurer.

(c) The total number of authorized, issued and outstanding voting securities of persons who control said insurer is:

_____

_____

(d) Of such latter number of shares, the undersigned and its affiliates (if any) own or control the voting rights (by proxy or otherwise) of _____ shares, or approximately _____ %.

(e) Other:

4. The basis for disclaiming affiliation between the undersigned and said insurer is (state and explain)

_____

_____

_____

5. The announced plan _____ (specify, e.g.: purchase of shares, exchange of shares, mergers, formation of a holding company) by the undersigned and relating to the above-named insurer, will not result in affiliation, without the meaning of California Insurance Code Section 1215, of the undersigned with said insurer, or vice versa, for the reason that:

_____

_____

_____

_____

IN WITNESS WHEREOF, the undersigned has hereunto signed its name and affixed its corporate seal at _____ in the State of _____ this _____ day of _____, 19 ____.

(CORPORATE SEAL) _____
Name of person making disclaimer

By _____
Title or position. Must be an executive officer.

(1) DISCLAIMER ALLOWED this_____day of _____, 19___, on the basis of the evidence presented herein.

_____
Insurance Commissioner of the State of California

By_____
Deputy

(2) NOTICE OF HEARING—RE DISALLOWANCE

You are hereby notified that there will be a public hearing in my offices, Room___ at _____on _____, 19___ commencing at _____o'clock ___M for the purpose of determining whether the within disclaimer should be disallowed. At such hearing all parties in interest may appear and present relevant evidence and argument to that end.

Dated_____, 19___.

_____
Insurance Commissioner of the State of California

By_____
Deputy

FORM DD (3–20–70)

To: The Insurance Commissioner of the State of California
Attn: Company Information and Analysis Division
1407 Market Street
San Francisco, California 94103

DISCLAIMER OF _____

FILED PURSUANT TO CALIFORNIA INSURANCE CODE SECTION 1215.4(i)

The undersigned hereby makes and files with the California Insurance Commissioner its disclaimer pursuant to the above mentioned Code section and declares that it is not affiliated with _____, an insurer holding a California certificate of authority. The undersigned hereby alleges that all material relationships and bases for affiliation between the undersigned and such insurer are:

_____

_____

The undersigned further declares that the basis for disclaiming any such affiliation is: _____

_____

This disclaimer is filed in duplicate so that, if the Commissioner allows the same, he may endorse this form accordingly and return a copy hereof for the company's records.

We hereby declare under penalty of perjury that the matters set forth above or in any exhibits, by reference, or incorporated herein, are true and correct.

Witness of signature and seal this _____ day of _____, 19 _____, at _____ in the State of _____

_____
Name of company

(CORPORATE SEAL) By _____
President or Vice–President

By _____
Secretary or Treasurer

INSTRUCTIONS

This disclaimer form may also be filed by an admitted insurer or any member of an insurance holding company system, within the meaning of the Insurance Holding Company system Regulatory Act by "x–ing" out the phrase "an insurer holding a California certificate of authority" in the fourth and fifth lines of the first paragraph of the body of the form. In such event, the company executing this form should describe itself as an insurer, or noninsurer, admitted or not admitted to this State, as appropriate.

* * * * * * *

Receipt of copy hereof is acknowledged. On the basis of the evidence presented hereby, the disclaimer is allowed. Unless, after due notice to and hearing of all parties in interest, and after making appropriate findings of fact, the Commissioner disallows the disclaimer, the above–named insurer is from the date its disclaimer was filed relieved of further duty to register or report under California Insurance Code Section 1215.4 until further notice.

Dated _____

_____
Insurance Commissioner of the State of California
By: _____
Deputy

Notice of Hearing—Re Disallowance

Please take notice that a public hearing will be held in my offices, Room_____at_____, California on_____,19___, commencing at_____o'clock ___m; for the purpose of determining whether the within disclaimer should be disallowed. At said hearing all parties in interest may appear and present relevant evidence, oral or written, and argument tending to show whether said _____ is or is not affiliated with _____.

Dated_____,_____

_____
Insurance Commissioner
By _____
Deputy

NOTE: Authority cited: Section 1215.8 Insurance Code. Reference: Sections 1215–1215.15 Insurance Code.

HISTORY

1. Amendment filed 11–29–79 as procedural and organizational; effective upon filing (Register 79, No. 48).

Subchapter 5.9. Privacy of Nonpublic Personal Information

Article 1. General Provisions

§ 2689.1. Authority and Purpose.

The Commissioner promulgates these regulations pursuant to the implied authority granted by California Insurance Code Sections 791 et seq. and 15 U.S.C. Sections 6801(b) and 6805(b) to implement California Insurance Code and Gramm–Leach–Bliley privacy provisions consistent with providing individuals the maximum privacy protections permitted by those laws.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Sections 791–791.27, Insurance Code.

HISTORY

1. New subchapter 5.9 (articles 1–5, sections 2689.1–2689.24), article 1 (sections 2689.1–2689.4) and section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.2. Scope.

These regulations govern the treatment of nonpublic personal information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes. These regulations shall apply to all licensees of the California Department of Insurance subject to California Insurance Code Sections 791 et seq., namely insurance institutions, agents, and insurance support organizations. Licensees not subject to California Insurance Code Sections 791 et seq., but subject to Gramm–Leach–Bliley (GLBA), 15 U.S.C. Sections 6801–6810, shall comply with GLBA privacy provisions and with Sections 2689.12 through 2689.20 of these regulations.

Licensees shall also comply with California Civil Code Section 1798.85 (SB 168, Chapter 720, Statutes of 2001), Business and Professions Code Sections 17590 through 17595 (SB 771, Chapter 695, Statutes of 2001), and all other applicable privacy and confidentiality provisions.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Sections 791.01 and 791.02, Insurance Code; Section 1798.85, Civil Code; Sections 17590, et seq., Business and Professions Code; and 15 U.S.C. Section 6803.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.3. Disclosure of Information.

Nonpublic personal information shall not be disclosed in a manner not permitted by California law or these regulations.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.13, Insurance Code.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.4. Definitions.

As used in these regulations, unless the context requires otherwise:

(a) "Clear and conspicuous" means that a notice is "reasonably understandable" and "designed to call attention to the nature and significance of the information" in the notice. All notices must be clear and conspicuous and accurately reflect the licensee's privacy policies and practices.

A notice is "reasonably understandable" if it:

(1) Presents information in clear, concise sentences, paragraphs, and sections;

(2) Uses short explanatory sentences (an average of 15–20 words) or bullet lists whenever possible;

(3) Uses definite, concrete, everyday words and active voice whenever possible;

(4) Avoids multiple negatives;

(5) Avoids legal and highly technical business terminology whenever possible;

(6) Avoids explanations that are imprecise and readily subject to different interpretations; and

(7) Achieves a minimum Flesch Reading Ease Score of 50. (The Flesch Reading Ease Score rates text on a 100–point scale — the higher the score, the easier it is to understand the document. The formula for the Flesch Reading Ease score is:

206.835 – (1.015 x ASL) – (84.6 x ASW)

where:

ASL = average sentence length (the number of words divided by the number of sentences)

ASW = average number of syllables per word (the number of syllables divided by the number of words).)

A notice is "designed to call attention to the nature and significance of the information" in it if it:

(8) Uses a plain–language heading to call attention to the notice;

(9) Uses an easy–to–read typeface and type size (at least 10 point);

(10) Provides wide margins and ample line spacing;

(11) Uses boldface or italics for key words;

(12) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars; and

(13) If on the back or inside of a multi–page form, is accompanied by a prominent notice on the front of the form directing the reader's attention to the privacy notice and where it may be found.

A notice on a web site is "designed to call attention to the nature and significance of the information" in it if it is rendered as a page using Hypertext Markup Language (html) in addition to any other webpage formats used, is at least the equivalent point size and type as the standard text on the licensee's web site, and, uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensures that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the notice is either:

(14) Placed on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(15) Accessed from a screen that consumers frequently access through a link that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

(b) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, regardless of the source of the underlying information.

(c) "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information. "Consumer" includes that individual's legal representative. Examples include, but are not limited to, the following:

(1) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service, is a consumer regardless of whether the licensee establishes an ongoing relationship.

(2) An applicant for insurance prior to the inception of insurance coverage is a consumer.

(3) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(4) An individual is a licensee's consumer if the individual is a beneficiary of a life insurance policy underwritten by the licensee, a claimant under an insurance policy issued by the licensee, an insured or an annuitant under an insurance policy or an annuity issued by the licensee, a certificate holder under an employee or other group policy, a bodily injury claimant against a commercial liability policy, a worker's compensation claimant, or a mortgagor of a mortgage covered under a mortgage insurance policy; and the licensee discloses nonpublic personal information about the individual to a nonaffiliated third party other than as permitted by California Insurance Code Section 791.13.

(5) If the licensee provides initial, annual and revised notices to the plan sponsor, group or blanket insurance policyholder, group annuity contractholder, or workers' compensation plan participant, and does not disclose to a nonaffiliated third party nonpublic personal information about such an individual other than as permitted under California Insurance Code Section 791.13, an individual is not the consumer of the licensee solely because of that relationship. If the licensee does not meet all the conditions of this paragraph, the described individuals are consumers of a licensee.

(6) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee or because he or she has designated the licensee as trustee for a trust.

(d) "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

A consumer has a continuing relationship with a licensee if the consumer is a current policyholder of an insurance product issued by or through the licensee; or the consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

A consumer does not have a continuing relationship with a licensee, and therefore is not a customer, if, for example:

(1) The consumer applies for insurance but does not purchase the insurance;

(2) The licensee sells the consumer travel insurance in an isolated transaction;

(3) The consumer is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(4) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(5) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(6) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

(7) The consumer is an insured or an annuitant under an insurance policy or annuity but is not the policyholder or owner of the insurance policy or annuity; or

(8) The consumer's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent good faith attempts by the licensee to obtain a current valid address for the individual have been unsuccessful. If so, and if the consumer has not opted out, the licensee shall, at least annually, remove the consumer's name from any list for marketing purposes for disclosure to a nonaffiliated third party.

(e) "Financial institution" means any institution engaged in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 US.C. 1843(k)).

Financial institution does not include:

(1) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 *et seq*);

(2) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 *et seq*); or

(3) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(f) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)). Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer or a financial product or service.

(g) "Nonaffiliated third party" means any person or entity that is not an affiliate of, or related by common ownership or affiliated by corporate control with, a licensee. Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

(h) "Nonpublic personal financial information" means personally identifiable financial information a consumer provides to a licensee to obtain an insurance product or service from the licensee, information

about a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer, or information the licensee obtains about a consumer in connection with providing an insurance product or service to that consumer.

"Nonpublic personal financial information" includes any list, description or other grouping of consumers that is derived using any personally identifiable financial information that is not publicly available. "Nonpublic personal financial information" does not include medical record information.

(i) "Nonpublic personal information" means "personal information" as defined in California Insurance Code Section 791.02(s). "Nonpublic personal information" includes "nonpublic personal financial information" and "medical record information" (as defined in California Insurance Code Section 791.02(q).

"Nonpublic personal information" includes any list, description or other grouping of consumers that is derived using any personally identifiable information that is not publicly available. "Nonpublic personal information" also includes any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer; any information the licensee collects through an Internet cookie (an information–collecting device from a web survey); and information from a consumer report.

If information about individuals associated with a business entity is collected or accessed in connection with a consumer transaction, or is used for marketing products or services intended for personal, family, or household purposes, it is nonpublic personal information for purposes of these regulations. Insurance transactions relating to products obtained by a policyholder for business, commercial, or agricultural purposes, but which actually provide insurance primarily for personal, family, or household purposes, involve nonpublic personal information for purposes of these regulations.

A dual purpose policy providing only incidental or supplemental commercial coverages is still a policy primarily for personal, family or household purposes for purposes of these regulations.

(j) "Opt–In" means that a licensee must obtain a consumer's permission before sharing certain nonpublic personal information with others.

(k) "Opt–Out" means that a licensee must allow a consumer the opportunity to prevent the sharing of certain nonpublic personal financial information with others.

(*l*) "Ownership of voting securities," as used in California Insurance Code Section 791.02(g), means ownership or power to vote twenty–five percent (25%) or more of the outstanding shares of any class of voting security of the person or entity, directly or indirectly, or acting through one or more other persons, and includes power in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the person or entity.

(m) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law.

A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine that the information is of the type that is available to the general public; and when an individual can direct that the information not be made available to the general public, the individual has not done so.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.04, Insurance Code; 15 U.S.C. Sections 6801, 6802, 6803 and 6809.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

Article 2. Privacy Notices; Opt Out Notices for Nonpublic Personal Financial Information

§ 2689.5. Initial Privacy Notice.

(a) In addition to any notice of information practices required by California Insurance Code Section 791.04, licensees shall provide notice as required by this section. Licensees may provide the notices required by California Insurance Code Section 791.04 and this section in a single combined notice or in separate notices, so long as all the requirements of California Insurance Code Section 791.04 and these regulations are satisfied. If a licensee uses a California notice and another separate notice, the California notice shall clearly state that any rights a consumer, claimant, or beneficiary may have as described in the California notice are not limited by the standard privacy notice that the licensee also uses.

A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(1) A customer, not later than when the licensee establishes a customer relationship, except as provided in subsection (c) of this section: and

(2) A consumer, claimant, or beneficiary before the licensee discloses any nonpublic personal information about the consumer, claimant, or beneficiary to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by California Insurance Code Section 791.13(a) through (j) or (*l*) through (r), unless the licensee has a customer relationship with the consumer, claimant, or beneficiary, or a notice has been provided by an affiliated licensee, the notice clearly identifies all licensees to whom the notice applies, and is accurate with respect to the licensee and the other institutions.

(b) When an existing customer obtains a new insurance product or service, intended primarily for personal, family, or household purposes, the licensee need not provide a new initial notice if the notice most recently provided by the licensee or an affiliate is accurate with respect to the licensee and the affiliate.

(c) A licensee may provide the initial notice required by subsection (a)(1) within a reasonable time after the licensee establishes a customer relationship if:

(1) Establishing the customer relationship is not at the customer's election; for example, if a licensee acquires or is assigned a customer's policy from another licensee or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(2) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction; for example, when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service. In that case, the customer shall be provided with oral notice of the licensee's privacy policies, provided that the privacy notice is mailed or provided in electronic form within fourteen (14) business days after the sale, and documentation is maintained showing that oral disclosure was provided to the customer. For licensees who do not disclose personal information other than as permitted by California Insurance Code Section 791.13, an oral disclosure is not required.

The customer's transaction is not substantially delayed when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.04, Insurance Code; 15 U.S.C. Section 6803.

HISTORY

1. New article 2 (sections 2689.5–2689.10) and section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.6. Annual Privacy Notice.

In addition to any notice of information practices required by California Insurance Code Section 791.04, licensees shall provide notice as required by this section. Licensees may provide the notices required by California Insurance Code Section 791.04 and this section in a single combined notice or in separate notices, so long as all the requirements of California Insurance Code Section 791.04 and these regulations are satisfied. If a licensee uses a California notice and another separate notice, the California notice shall clearly state that any rights a consumer, claimant, or beneficiary may have as described in the California notice are not limited by the standard privacy notice that the licensee also uses.

A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve–consecutive–month period, but the licensee shall apply it to the customer on a consistent basis. A licensee is not required to provide an annual notice to a former customer with whom it no longer has a continuing relationship.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.04, Insurance Code; and 15 U.S.C. Section 6803.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.7. Information To Be Included in Privacy Notices.

(a) The initial, annual and revised privacy notices that a licensee provides under Sections 2689.5, 2689.6, and 2689.9 shall, at a minimum, include each of the following that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal information that the licensee collects;

(2) The categories of nonpublic personal information that the licensee discloses;

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information, and the general types of businesses in which the third parties engage if the information is disclosed pursuant to California Insurance Code Section 791.13(k);

(4) The categories of nonpublic personal information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information about the licensee's former customers, if the information is disclosed pursuant to California Insurance Code Section 791.13(k);

(5) If a licensee wishes to disclose or reserve the right to disclose nonpublic personal financial information to an affiliate for marketing purposes without affirmative authorization or the right to opt out of that disclosure, a statement explaining that the licensee may disclose nonpublic personal financial information to affiliates for marketing purposes without obtaining prior authorization and the law does not allow customers to restrict that disclosure.

(6) An explanation of the consumer's right to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(7) Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) regarding the ability to opt out of disclosures of information among affiliates;

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information, including a general description as to who is authorized to have access to the information;

(9) If applicable, a statement that the consumer has the right to access and request correction of recorded nonpublic personal information and a brief description of the manner in which those rights may be exercised; and

(10) The categories of disclosures that the licensee makes under California Insurance Code Section 791.13.

(11) If applicable, the statement required by California Insurance Code Section 791.04(b)(5).

(12) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(b) If prior authorization is not required and a licensee reserves the right to disclose all of the nonpublic personal information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(c) An abbreviated notice, as provided for in California Insurance Code Section 791.04(c), shall comply with California Insurance Code Section 791.04(c) and:

(1) Be clear and conspicuous;

(2) Describe a reasonable means by which the consumer may obtain the notice prescribed by California Insurance Code Section 791.04(b), such as calling a toll–free telephone number to request the notice. If the consumer is provided the abbreviated notice in person at the licensee's office, the abbreviated notice may state that the licensee maintains copies of the notice on hand which will be provided to the consumer immediately upon request; and

(3) If applicable, contain an opt–out notice complying with these regulations.

This section does not prohibit the use of multiple links on a website to different categories or levels of information, as long as they are designed to facilitate rather than impede access.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Sections 791.04, 791.05, 791.06 and 791.13, Insurance Code.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.8. Form of Opt Out Notice and Opt Out Methods.

(a) If a licensee is required to provide an opportunity to opt–out before it shares any nonpublic personal financial information with a nonaffiliated third party, it shall provide a clear and conspicuous notice to the consumer, that clearly states in 16–point boldface type "IMPORTANT PRIVACY CHOICES", or similarly highlights the purpose of the notice, so that the consumer may make a decision and provide direction to the licensee regarding the sharing of his or her nonpublic personal financial information.

If a licensee provides the opt out notice later than the initial notice, the licensee shall also include, with the opt–out notice, a copy of the initial notice in writing or, if the consumer agrees, electronically.

The notice shall state that the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumers to nonaffiliated third parties, that the consumer has the right to opt out of that disclosure, and set forth reasonable means by which the consumer may exercise the opt out right.

A licensee provides adequate notice that the consumer can prevent the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee (1) identifies all of the categories of nonpublic personal financial information which it discloses or reserves the right to disclose, (2) all of the categories of nonaffiliated third parties to which it discloses the information, (3) states that the consumer can prevent the disclosure of that information, and identifies the insurance products or services that the consumer obtains from the licensee to which the opt out direction would apply.

A licensee provides a reasonable means to exercise an opt out right if it designates check–off boxes in a prominent position on the relevant forms with the opt out notice; includes a reply form together with the opt–

out notice; provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information. Unless the consumer agrees to an electronic opt–out method, the licensee shall provide a self–addressed postage prepaid return envelope or a toll–free telephone number that consumers may use to opt out.

A licensee does not provide a reasonable means of opting out if, for example, the only means of opting out is for the consumer to write his or her own letter to exercise that opt out right, or the only means of opting out as described in any notice subsequent to the initial notice is to use a check–off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(b) If a licensee mails the opt–out notice with information that is not a bill or renewal offer, the opt–out notice shall be the first page of the mailing.

(c) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information if the licensee is an employee or agent of another licensee ("the principal") and:

(1) The principal otherwise complies with, and provides the required notices; and

(2) The licensee does not disclose any nonpublic personal financial information to any person other than the principal or its affiliates in a manner permitted by California Insurance Code Sections 791–791.27 or these regulations.

(3) A licensee not otherwise subject to the notice and opt out requirements for nonpublic personal financial information, pursuant to sections 2689.8(c)(1) and (2), is subject to the notice and opt out requirements, pursuant to California Insurance Code Section 791.13(k), if the licensee, prior to issuance of a renewal policy or at any other time, shares nonpublic personal financial information with any person other than the insurer which issued the existing policy. A licensee shares nonpublic personal financial information with a person other than the insurer which issued the existing policy if the licensee shares nonpublic personal financial information with another insurer in an effort to obtain a renewal policy on more favorable terms than the existing policy.

(d) When a consumer has declined to exercise the right to opt out in accordance with this section, the nonpublic personal financial information disclosed:

(1) May not exceed the scope of disclosure stated in the licensee's opt–out notice;

(2) May not include account number, or policy number information; and

(3) Shall comply with California Insurance Code Section 791.13(k)(1).

(e) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice, as long as the licensee gives clear and conspicuous notice that the notice is being provided on a joint basis and the consumers have given the licensee a single address of record or the licensee has other reasonable basis to believe that the notice will be adequately communicated to each individual entitled to receive notice.

The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer. Any of the joint consumers may exercise the right to opt out. The licensee may either treat an opt out direction by a joint consumer as applying to all of the associated joint consumers or permit each joint consumer to opt out separately. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers. A licensee may not require all joint consumers to opt out before it implements any opt out direction. If one joint policyholder opts out and the other does not, the licensee may only disclose nonpublic personal financial information about the policyholder who did not opt out and may not disclose information relating to the policyholders jointly.

(f) A consumer may exercise the right to opt out at any time. A licensee may share marketing information with nonaffiliated third parties if a consumer does not respond within 30 days. A licensee shall not share information for marketing purposes before the conclusion of the 30–day time period. If a consumer provides an opt–out direction after the licensee has begun sharing nonpublic personal financial information, the licensee shall comply with the opt–out direction no later than 30 days after the licensee receives the opt out direction.

(g) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or electronically, at the consumer's choice.

When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(h) Any authorized representative may opt out on behalf of the consumer. A licensee receiving notice that a consumer has opted out shall not require proof of authorization unless it has a reasonable basis for believing that the person submitting the opt–out direction was acting contrary to the wishes of the consumer.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.13. Insurance Code; and 15 U.S.C. Section 6802.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.9. Revised Privacy Notices.

(a) Except as otherwise authorized, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal information about a consumer to a nonaffiliated third party other than as described in the notice provided to that consumer unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new opt out notice which complies with section 2689.8 and;

(3) The consumer does not opt out in accordance with section 2689.8.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. 6801, 6805 and 6807. Reference: Section 791.13, Insurance Code; and 15 U.S.C. Section 6802.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.10. Delivery of Notices.

(a) A licensee shall provide any required notices, including notices provided at the consumer's request, so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically. Notices must be made available in a form capable of retention by the consumer.

A licensee may reasonably expect that a consumer will receive actual notice if the licensee, for example:

(1) Hand–delivers a printed copy of the notice to the consumer;

(2) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(3) For a consumer who conducts transactions electronically, posts the notice on the electronic site in accordance with section 2689.4(a) and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(4) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice in a conspicuous location and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

A licensee may not reasonably expect that a consumer will receive actual notice if it:

(5) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(6) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(b) A licensee may not provide any notice required by these regulations solely by orally explaining the notice, either in person or over the telephone.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.04, Insurance Code; and 15 U.S.C. Sections 6802 and 6803.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

Article 3. Limits on Disclosures of Medical Record Information

§ 2689.11. Disclosure of Medical Record Information.

(a) A licensee shall not disclose nonpublic personal medical record information about a consumer to affiliated or nonaffiliated third parties without the consumer's prior written authorization.

(b) This section does not prohibit or restrict the disclosure of nonpublic personal medical record information as permitted by California Insurance Code Section 791.13 or require an authorization for disclosure of nonpublic personal medical record information other than as required by California Insurance Code Section 791.13.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.13, Insurance Code.

HISTORY

1. New article 3 (section 2689.11) and section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

Article 4. Standards for Safeguarding Nonpublic Personal Information

§ 2689.12. General Provisions.

(a) This article establishes standards for developing and implementing administrative, technical, and physical safeguards to protect the security, confidentiality, and integrity of nonpublic personal information, pursuant to California Insurance Code Section 791 and sections 501, 505(b), and 507, codified at 15 U.S.C. 6801, 6805(b) and 6807, of GLBA.

(b) The actions and procedures described in sections 2689.16, 2689.17, 2689.18, and 2689.19 are examples of methods of implementation of the requirements of sections 2689.14 and 2689.15. These examples are non–exclusive illustrations of actions and procedures that licensees may follow to implement sections 2689.14 and 2689.15 of these regulations.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807.

HISTORY

1. New article 4 (sections 2689.12–2689.20) and section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.13. Definitions.

For purposes of this article, the following definitions apply:

(a) "Customer information systems" means the electronic or physical methods used to access, collect, store, use, transmit, protect, or dispose of nonpublic personal information, whether that information is maintained in paper, electronic, or other form.

(b) "Service provider" means any person or entity that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to the licensee.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6827.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.14. Information Security Program.

Each licensee shall implement a comprehensive written information security program that includes administrative, technical and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6825.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.15. Objectives of Information Security Program.

A licensee's information security program shall be designed to:

(a) Ensure the security and confidentiality of customer information;

(b) Protect against any anticipated threats or hazards to the security or integrity of such information; and

(c) Protect against unauthorized access to or use of such information that could result in substantial harm or inconvenience to any customer.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6825.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.16. Assess Risk.

The licensee:

(a) Identifies reasonably foreseeable internal and external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;

(b) Assesses the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and

(c) Assesses the sufficiency of policies, procedures, customer information systems, and other safeguards in place to control risks.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6825.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.17. Manage and Control Risk.

The licensee:

(a) Designs its information security program to control the identified risks, commensurate with the sensitivity of the information as well as the complexity and scope of the licensee's activities.

(b) Trains staff, as appropriate, to implement the licensee's information security program; and

(c) Regularly tests or otherwise regularly monitors the key controls, systems and procedures of the information security program. The frequency and nature of the tests are determined by the licensee's risk assessment.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6825.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.18. Service Providers.

The licensee:

(a) Exercises appropriate due diligence in selecting its service providers; and

(b) Requires its service providers, by contract, to implement appropriate measures designed to meet the objectives of this article, and, where indicated by the licensee's risk assessment, takes appropriate steps to confirm that its service providers have satisfied such obligations.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6825.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.19. Adjust the Program.

A licensee monitors, evaluates, and adjusts, as appropriate, the information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats

to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, outsourcing arrangements, and changes to customer information systems.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791, Insurance Code; and 15 U.S.C. Section 6825.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.20. Enforcement.

The Commissioner shall audit a licensee's compliance with this article in a manner and with such frequency as the Commissioner deems necessary. Violations of this article are subject to California Insurance Code Section 791.15, *et seq.* and any other enforcement provisions available to the Commissioner.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805, 6807 and 6824. Reference: Section 791.15, Insurance Code.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

Article 5. Additional Provisions

§ 2689.21. Protection of Fair Credit Reporting Act.

Nothing in these regulations shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*), and no inference shall be drawn on the basis of the provisions of these regulations regarding whether information is transaction or experience information under Section 603 of that Act.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: 15 U.S.C. Section 6806.

HISTORY

1. New article 5 (sections 2689.21–2689.24) and section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.22. Nondiscrimination.

A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal information pursuant to the provisions of these regulations.

A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal medical record information pursuant to the provisions of these regulations.

As used in this section, "unfairly discriminate" includes denying a consumer or customer a product or service because he or she has not provided the consent required to authorize the financial institution to disclose or share his or her nonpublic personal information as provided in California Insurance Code Section 791.13(k).

NOTE: Authority cited: Sections 791–791.13, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791.13, Insurance Code.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.23. Severability.

If any section or portion of a section of these regulations or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791, Insurance Code.

HISTORY

1. New section filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

§ 2689.24. Effective Date; Contracts with Nonaffiliated Third Parties.

These regulations are effective one hundred and twenty (120) days after they are filed with the Secretary of State. If that day falls on a Saturday, Sunday, or any holiday set forth in California Government Code Section 6700, the regulations shall become effective on the next business day.

Within 90 days of the effective date of these regulations, all contracts that a licensee enters into or has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf shall include or be amended to include a written requirement that the third party maintain the confidentiality of nonpublic personal information where the nonaffiliated third party obtains confidential nonpublic personal information in connection with the contract.

NOTE: Authority cited: Sections 791–791.27, Insurance Code; and 15 U.S.C. Sections 6801, 6805 and 6807. Reference: Section 791, Insurance Code.

HISTORY

1. New section and Appendix A filed 11–22–2002; operative 3–24–2003 (Register 2002, No. 47).

Appendix A — Sample Clauses

If applicable, a licensee may use the following sample clauses in its notices. A group of financial holding company affiliates using a common privacy notice may use these clauses if accurate for each company. These clauses are not exclusive. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may result in obligations under the federal Fair Credit Reporting Act.)

Categories of information collected

The following language may be used to describe the categories of personal information collected.

We collect personal information about you from:

- Applications or other forms you complete;
- Your business dealings with us and other companies; and
- Consumer reporting agencies.

Categories of information disclosed

The following language may be used to describe the categories of personal information disclosed.

Alternative 1:

We may disclose the following personal information about you:

- Information from your application or other forms, such as your name, address, social security number, assets, income, and beneficiaries;
- Information about your transactions with us, our affiliates or others, such as your policy coverage, premiums, and payment history; and
- Information from consumer reporting agencies, such as your credit history.

Alternative 2:

We may disclose all the information that we collect about you.

To whom information is disclosed

The following language may be used to describe the persons to whom the licensee discloses information.

Alternative 1:

We do not disclose any personal information about you to anyone unless allowed by law. The law allows us to share your financial information with our affiliates to market products or services to you. You cannot prevent those disclosures.

Alternative 2:

We may disclose personal information about you to:

- Financial companies, such as life insurers, automobile insurers, mortgage bankers, securities broker–dealers, and insurance agents;
- Companies, such as retailers, direct marketers, airlines, and publishers; and
- Others, such as non–profit organizations.

Alternative 3:

We may also disclose personal information about you as allowed by law. The law allows us to share your financial information with our affiliates to market products or services to you. You cannot prevent those disclosures.

Explanation of opt out right

The following language may be used to explain the consumer's right to opt out of the disclosure of personal financial information to nonaffili-

ated third parties and how the consumer may exercise that right, when the licensee discloses personal information as permitted by California Insurance Code Section 791.13(k)(2).

If you don't want us to disclose personal information about you to nonaffiliated companies, you may tell us so. This is known as "opting out". If you wish to opt out, call us at 1–800___–____ or complete and return the enclosed form. We may share information about you if we do not hear from you within 30 days. However, you may opt–out at any time. Just call or write us. Even if you opt–out, we may still disclose information as allowed by law. This includes disclosing information to our affiliates to market other products or services to you.

Confidentiality and security

The following language may be used to describe how a licensee protects the confidentiality and security of personal information.

We protect your nonpublic personal information. The only employees who have access to that information are those who must have it to provide products or services to you.

Subchapter 6. Conflict of Interest Code for the Department of Insurance

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict of interest codes. The Fair Political Practices Commission (FPPC) has adopted a regulation (2 California Code of Regulations Section 18730) containing the terms of a standard conflict of interest code, which can be incorporated by reference in an agency's code. After public notice and hearing it may be amended by the FPPC to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the FPPC are hereby incorporated by reference. This regulation and the attached Appendix designating officials and employees and establishing disclosure categories, shall constitute the conflict of interest code of the Department of Insurance.

Designated employees shall file their statement of economic interests with the Department of Insurance who will make the statements available for public inspection and reproduction (Government Code Section 81008). Upon receipt of the statements of the Insurance Commissioner and Chief Deputy Insurance Commissioner, the agency shall make and retain a copy and forward the original of these statements to the FPPC. Statements for all other designated employees will be retained by the Department of Insurance.

§ 2690. Introduction.

NOTE: Authority cited for Subchapter 6: Section 87300, Government Code. Reference; Section 87302 (a), (b) and (c), Government Code.

HISTORY

1. New Subchapter 6 (Sections 2690–2690.65) filed 5–2–77; effective thirtieth day thereafter. Approved by Fair Political Practices Commission 3–17–77 (Register 77, No. 19).
2. Repealer of section and new introductory paragraphs filed 10–17–95; operative 11–16–95. Approved by Fair Political Practices Commission 8–7–95. Submitted to OAL for printing only (Register 95, No. 42).
3. Amendment of introductory paragraphs filed 1–21–2003; operative 2–20–2003. Approved by Fair Political Practices Commission 11–12–2002 (Register 2003, No. 4).

§ 2690.1. Designated Employees; Disclosure Category.

Designated Employees	*Disclosure Category*
Insurance Commissioner	1
All Other Commissioners (Chief Deputy, Deputy, Assistant, etc.)	1
All Special Assistants to the Commissioner	1
All Administrative Law Judges	1
All Division Chiefs	2
Chief, Ethics and Operational Compliance Office	2
All Staff Counsels (regardless of rank)	2
All Legal Assistants and Para–Legals (regardless of rank)	2
All Insurance Investigators (regardless of rank)	2
All Insurance Compliance Officers (regardless of rank)	2
All Consultants*	2
All Investment Officers (regardless of rank)	2
All Actuaries (regardless of rank)	2
All Insurance Rate Analysts (regardless of rank)	2
All Information Officers	2
All Insurance Claims Specialists	2
All Insurance Examiners (regardless of rank)	2
All Staff Services Managers, Licensing Services Division	3
All Program Technician, Producer Licensing Bureau (regardless of rank)	3
Associate Government Program Analyst, Education Unit, Producer Licensing Bureau	3
All Staff Services Analyst, Education Unit, Producer Licensing Bureau	3
All Associate Government Program Analyst, Examination Unit, Producer Licensing Bureau	3
All Associate Government Program Analyst, Licensing Background Bureau (regardless of rank)	3
All Staff Services Analyst, Licensing Background Bureau (regardless of rank)	3
All Program Technicians, Licensing Background Bureau (regardless of rank)	3
Chief, Accounting Services Bureau	3
Chief, Human Resources Management Bureau	4
Chief, Administrative Systems	4
All Other Staff Services Managers	4
All Data Processing Managers	4
All Contract Analysts and Procurement Staff	4
All Information Technology Staff and Senior Analysts (regardless of rank)	4
Information Systems Analysts, Project Management Office	4
All Fraud Investigators (regardless of rank)	5
All Auditors, Audit Supervisor and all Staff Services Analysts in the Fraud Special Investigative Unit (SIU) Compliance Review Office (regardless of rank)	5
All Auditors and Audit Supervisor in the Fraud Grant Audit Unit (regardless of rank)	5

* The Commissioner may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that are limited in scope and thus is not required to fully comply with the disclosure requirements described in this section. Such written determination shall include a description of the consultant's duties and, based on that description, a statement of the extent of the disclosure requirements. The Commissioner's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code.

NOTE: Authority cited: Section 87300, Government Code. Reference: Section 87302 (a), (b) and (c), Government Code.

HISTORY

1. Repealer and new section filed 10–17–95; operative 11–16–95. Approved by Fair Political Practices Commission 8–7–95. Submitted to OAL for printing only (Register 95, No. 42).
2. Amendment filed 1–21–2003; operative 2–20–2003. Approved by Fair Political Practices Commission 11–12–2002 (Register 2003, No. 4).
3. Amendment filed 11–15–2005; operative 12–15–2005. Approved by Fair Political Practices Commission 9–30–2005 (Register 2005, No. 46).

§ 2690.2. Disclosure Categories.

Designated employees in Category I shall report the following:

(1.) Any investment in a business entity.

(2.) Any interest in real property.

(3.) Income for any source.

(4.) Any business positions.

Designated employees in Category 2 shall report the following:

(1.) Any investment in a business entity which, within the preceding 24 months, has been subject to regulation by or under the jurisdiction of the Department.

(2.) Income from any source, provided that the income was furnished by or on behalf of any person who, within the preceding 24 months, has been subject to regulation by or under the jurisdiction of the Department.

Designated employees in Category 3 shall report the following:

(1.) Any investment in a business entity required to be licensed by the Department or which provides education or training which, within the preceding 24 months, has been required by the Department to qualify for or maintain a license.

(2.) Income from any source, provided that the income was furnished by or on behalf of any person who, within the preceding 24 months:

(a.) Has been licensed by the Department;

(b.) Has provided education or training required by the Department.

Designated employees in Category 4 shall report the following:

(1.) Any investment in a business entity or income from any source of the type which, within the preceding 24 months, has provided directly or indirectly, goods, services, or equipment to the Department.

(2.) Any interest in real property which, within the preceding 24 months, has been purchased, leased, or rented by the Department or any unit within the Department.

(3.) His or her status as a director, officer, partner, trustee, or holder of a position of management in any business entity which is of a type which, within the preceding 24 months, has provided directly or indirectly, goods, services or equipment to the Department.

Designated employees in Category 5 shall report the following:

(1.) Any investment in a business entity or income from any source which has been the subject of investigation by the designated employee during the past 12 months.

NOTE: Authority cited: Section 87300, Government Code. Reference: Section 87302 (a), (b) and (c), Government Code.

HISTORY

1. Repealer and new section filed 10–17–95; operative 11–16–95. Approved by Fair Political Practices Commission 8–7–95. Submitted to OAL for printing only (Register 95, No. 42).
2. Amendment filed 1–21–2003; operative 2–20–2003. Approved by Fair Political Practices Commission 11–12–2002 (Register 2003, No. 4).

§ 2690.3. Designated Employees; Scope of Disclosure.

HISTORY

1. Repealer filed 10–17–95; operative 11–16–95. Approved by Fair Political Practices Commission 8–7–95. Submitted to OAL for printing only (Register 95, No. 42).

§ 2690.4. Requirement That Each Designated Employee File an Annual Statement of Economic Interest.

(a) Manner of Disclosing Reportable Items.

Disclosure statements shall be made on forms supplied by the Department and shall contain the following information:

(1) Contents of Investment and Real Property Statements:

When an investment or an interest in real property is required to be disclosed under this section, the statement shall contain:

(A) A statement of the nature of the investment or interest;

(B) The name of the business entity in which each investment is held, and a general description of the business activity in which the business entity is engaged;

(C) The address or other precise location of the real property provided, however, that an interest in real property does not include the principal residence of the filer;

(D) A statement whether the fair market value of the investment or interest in real property exceeds ten thousand dollars ($10,000), and whether it exceeds one hundred thousand dollars ($100,000);

(E) In the case of an investment which constitutes fifty percent or more of the ownership interest in a business entity, disclosure of the investments and interest in real property of the business entity;

(F) In the case of an annual or leaving office statement, if the investment or interest in real property was partially or wholly acquired or disposed of during the period covered by the statement, the date of acquisition or disposal.

(2) Contents of Income Statements.

When income is required to be reported under this section, the statement shall contain:

(A) The name and address of each source of income aggregating two hundred and fifty dollars ($250) or more in value, or twenty five dollars ($25) or more in value if the income was a gift, and a general description of the business activity, if any, of each source.

(B) A statement whether the aggregate value of income from each source was greater than one thousand dollars ($1,000), and whether it was greater than ten thousand dollars ($10,000);

(C) A description of the consideration, if any, for which the income was received;

(D) In the case of a gift, the amount and the date on which the gift was received;

(E) Notwithstanding the above, income does not include salary and reimbursement for expenses or per diem received from a federal government agency.

(3) Contents of Business Entity Income Reports:

When income of a business entity, including income of a sole proprietorship, is required to be reported, the statement shall contain:

(A) The name, address, and a general description of the business activity of the business entity;

(B) In the case of a business entity which provides legal or brokerage services, the name of every person who paid fees to the business entity if the filer's pro rata share of fees from such person was equal to or greater than one thousand dollars ($1,000);

(C) In the case of a business entity not covered by paragraph (B), the name of every person from whom the business entity received payments if the filer's pro rata share of gross receipts from such person was equal to or greater than ten thousand dollars ($10,000) during the calendar year.

(b) Place and Time for Filing.

(1) All designated employees required to submit a statement of financial interests shall file the original with the Chief, Staff Services and Producer Licensing Division, who shall be the filing officer. Upon receipt of the statement the filing officer shall date stamp and retain the original and return a copy to the employee, provided, however, that with regard to the statement filed by the Commissioner, the filing officer shall forward the original to the Fair Political Practices Commission, retain one copy, and return a copy to the Commissioner.

(2) The initial statement shall be filed within thirty days after the effective date of this Conflict of Interest Code. The designated employee shall disclose any reportable investment and interest in real property held on the effective date. Thereafter, new civil service designated employees shall file an initial statement within thirty days after assuming employment. Persons holding the position of Commissioner, Chief Deputy Insurance Commissioner, or Chief Assistant Insurance Commissioner shall file a statement not less than ten days before assuming office.

(3) An annual statement shall be filed annually by the last day of February. The annual statement shall include any investments and interests in any real property held and income received at any time during the period covered by the statement whether or not such reportable items are still held at the time of filing.

(4) Every employee who leaves a designated position shall file a leaving office statement within thirty days after leaving, disclosing any reportable investments, and interests in real property held and income received during the period since the closing date of the previous statement and the date of termination, whether or not such reportable items are still held at the time of filing.

§ 2690.5. Circumstances Under Which Designated Employees Must Disqualify Themselves from Making or Participation in the Making of Government Decisions.

(a) When Disqualification Required.

Designated employees must disqualify themselves from making or participating in the making of a governmental decision when the designated employee has a financial interest, as set forth below, which it is reasonably foreseeable may be affected materially by the decision.

For purposes of this section, a designated employee has a financial interest in a decision if it is reasonably foreseeable that the decision will have a material financial effect, distinguishable from its effect on the public generally, on:

[The next page is 749.]

(1) Any business entity in which the designated employee has a direct or indirect investment worth more than one thousand dollars ($1,000);

(2) Any real property in which the designated employee has a direct or indirect investment worth more than one thousand dollars ($1,000);

(3) Any source of income, other than loans by a commercial lending institution in the regular course of business, aggregating two hundred fifty dollars ($250) or more in value received by or promised to the designated employee within twelve months prior to the time when the decision is made; or

(4) Any business entity in which the designated employee is a director, officer, partner, trustee, employee, or holds any position of management.

For the purpose of this section, in determining the existence of a material effect upon a financial interest, consideration should be given, but not limited to, an analysis of the following factors:

(1) In the case of a business entity in which the public official has a direct or indirect investment worth more than one thousand dollars ($1,000), or in the case of a public official who is a director, officer, partner, trustee, employee or holds any position of management in a business entity:

(A) Whether the effect of the decision will be to increase or decrease the annualized gross revenue of the business entity by one percent or more or the annual net income of the business entity by .5 percent or more;

(B) Whether the effect of the decision will be to increase or decrease the assets or liabilities of the business entity by $50,000 or more or by .5 percent of its current assets or liabilities, whichever is less;

(2) In the case of any real property in which the public official has a direct or indirect interest worth more than one thousand dollars ($1,000);

(A) Whether the effect of the decision will be to increase the income-producing potential of the real property by $100 or five percent per month, whichever is less.

(B) Whether the effect of the decision will be to increase the fair market value of the real property by $1,000 or more or by .5 percent, whichever is greater;

(3) In the case of a source of income of a public official as defined in Government Code Section 87103(c):

(A) The decision will affect the source of income in the manner described in subsection (1) above;

(B) Whether the governmental decision will directly affect the amount of income to be received by the official;

(C) Whether there is a nexus between the governmental decision and the purpose for which the official receives income.

The specific dollars or percentage amounts set forth above do not constitute either absolute maximum or minimum levels, but are merely intended to provide guidance and should be considered along with other relevant factors in determining whether a financial interest may interfere with the official's exercise of his or her duties in rendering a decision.

For purposes of this section, indirect investment or interest means any investment or interest owned by the spouse or dependent child of a designated employee, by an agent on behalf of a designated employee, by any business entity controlled by the designated employee or by a trust in which he has a substantial interest. A business entity is controlled by a designated employee if the designated employee, his agents, spouse and dependent children hold more than fifty percent of the ownership interest in the entity. A designated employee has a substantial interest in a trust when the employee, his spouse and dependent children have a present future interest worth more than one thousand dollars ($1,000).

(b) Manner of Disqualification.

In the event a designated employee is assigned a matter which requires his or her disqualification, the employee shall execute a disqualification statement. The employee shall give the statement to the immediate supervisor. The supervisor shall return one copy to the designated employee, forward a copy to the filing officer of the Department and one copy shall be placed in the assignment's file. Upon receipt of such statement, the supervisor shall immediately reassign the matter to another employee.

If the designated employee is in doubt whether to disqualify, the employee shall, by written memorandum, request a determination to be made by the supervisor. The supervisor shall record the determination made on the memorandum submitted by the employee.

One copy shall be given to the employee, a copy shall be directed to Personnel, and one copy shall be placed in the assignment's file.

If, after a designated employee has requested a determination as to whether he must disqualify himself from making or participating in the making of a governmental decision, the Commissioner determines the designated employee's financial interest is not such that the employee's official duties would have, or foreseeably have, a material financial effect on such interest, or the effect of the employee's decision as to the financial interest would be indistinguishable from its effect on the public generally, then the employee shall proceed with his official duties with respect to the matter.

A designated employee who has complied in good faith with a determination made by supervisor or by the Commissioner shall not be subject to any disciplinary action by the Department in connection with the assignment regarding which advice was sought, provided that the facts concerning the employee's financial interest were fairly represented by the employee.

§ 2690.6. Duties of the Filing Officer.

The filing officer shall:

(a) Supply the necessary forms and manuals prescribed by the Commission;

(b) Determine whether required documents have been filed and, if so, whether they conform on their face with the requirements of this title;

(c) Notify promptly all persons and known committees who have failed to file a report or statement in the form and at the time required by this title;

(d) Report apparent violations of this title to the appropriate agencies; and

(e) Compile and maintain a current list of all reports and statements filed with this office.

§ 2690.65. Disclosure Statement a Public Record.

Financial statements filed pursuant to this Code are public records open for public inspection and reproduction during regular business hours, commencing as soon as practicable, but in any event not later than the second business day following the day on which received. No conditions whatsoever shall be imposed upon persons desiring to inspect or reproduce such statements filed under this Code, no shall any information or identification be required from such persons. Copies shall be provided at a charge not to exceed ten cents ($0.10) per page.

Subchapter 6.5. Financial Examinations of Derivative Transactions

Article 1. Conflicts of Interest

§ 2690.90. Purpose.

Insurance Code section 1211 authorizes a domestic incorporated insurer to engage in derivative transactions, as defined, subject to specified conditions.

Subsection (*l*) of section 1211 provides that the Commissioner may adopt rules and issue guidelines establishing standards and requirements relative to practices authorized by section 1211. In connection with any of the actions contemplated by section 1211 to be taken by the Commissioner, including review of an insurer's written guidelines with respect to derivative transactions and review of the documentation maintained by an insurer with respect to derivative transactions, the Commissioner may deem the actions to be an examination of an insurer subject to the provisions of sections 730 to 738, inclusive.

Further, subsection (*l*) requires the Commissioner to issue regulations establishing requirements regarding the disclosure of affiliations and

conflicts of interest between an insurer and the person(s) assigned to perform such examinations.

NOTE: Authority cited: Section 1211(*l*), Insurance Code. Reference: Sections 730, 733, 734, 734.1, 735, 735.5, 736, 737 and 1211, Insurance Code.

HISTORY

1. New subchapter 6.5, article 1 (sections 2690.90–2690.94) and section filed 12–19–2006; operative 1–18–2007 (Register 2006, No. 51).

§ 2690.91. Definitions.

For purposes of section 2690.94, the following terms shall have the respective meanings hereinafter set forth:

(a) "Investment Consultant" shall refer, as appropriate, to either a natural person or a company engaged in the evaluation and assessment of derivative transactions, assigned by the Commissioner to perform the work authorized under section 1211.

(b) "Affiliate" or "affiliation" is defined as follows:

(1) Parent subsidiary. A parent subsidiary relationship exists when one corporation directly or indirectly owns shares possessing more than 10 percent of the voting power of another corporation.

(2) Otherwise related business entity. Business entities, including corporations, partnerships, joint ventures and any other organizations and enterprises operated for profit, which do not have a parent subsidiary relationship are otherwise related if any one of the following three tests is met:

(A) One business entity has a controlling ownership interest in the other business entity.

(B) There is shared management and control between the entities. In determining whether there is shared management and control, consideration shall be given to the following factors:

1. The same person or substantially the same person owns and manages the two entities;

2. There are common or commingled funds or assets;

3. The business entities share the use of the same offices or employees, or otherwise share activities, resources or personnel on a regular basis;

4. There is otherwise a regular and close working relationship between the entities;

(C) A controlling owner (50% or greater interest as a shareholder or as a general partner) in one entity also is a controlling owner in the other entity.

(c) "Conflict of interest" — an Investment Consultant has reportable conflicts of interest with regard to a particular company if the Investment Consultant has one or more economic interests in that company.

(1) "Economic interests" — there are three types of economic interests.

(A) Investment in the Company — The Investment Consultant has a direct or indirect investment worth two thousand dollars ($2,000) or more in the Company.

(B) Sources of Income —

1. The Investment Consultant has received income from the Company, or affiliated company, within the last 12 months or during the period of time for which the examination will apply.

2. The Investment Consultant holds or held a position in the Company, or affiliated company, within the last 12 months or during the period of time for which the examination will apply. Such position includes, but is not limited to, director, officer, partner, trustee, employee, or any position of management.

(C) Sources of Gifts — The Investment Consultant has received from the Company, or affiliated company, gifts with a fair market value of three hundred sixty dollars ($360)[1] or more within the last 12 months or during the period of time for which the examination will apply.

(d) "Company" is a domestic insurance company, or a group of insurance companies that includes a domestic insurance company, being examined and also includes those entities contracted by insurance company (ies) to perform investment management, provide investment advice, and any other related investment services.

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[1] This threshold amount is linked to the threshold established by the Fair Political Practices Commission in California Code of Regulations, Title 2, Division 6, Section 18703.4. The terms of section 18703.4 and any amendments to it duly adopted by the FPPC are hereby incorporated by reference.

NOTE: Authority cited: Section 1211(*l*), Insurance Code. Reference: Section 1211, Insurance Code; and California Code of Regulations, Title 2, Chapter 7, Sections 18703.1 and 18703.4.

HISTORY

1. New section filed 12–19–2006; operative 1–18–2007 (Register 2006, No. 51).

§ 2690.92. Disclosure.

Prior to assigning an Investment Consultant to conduct examinations of matters authorized by section 1211, the Department of Insurance shall require the Investment Consultant to complete the Conflict of Interest and Disclosure of Affiliation Form.

NOTE: Authority cited: Section 1211(*l*), Insurance Code. Reference: Section 1211, Insurance Code.

HISTORY

1. New section filed 12–19–2006; operative 1–18–2007 (Register 2006, No. 51).

§ 2690.93. Confidentiality.

The Conflict of Interest and Disclosure of Affiliation Form shall be confidential in accordance with Insurance Code section 735.5(c).

NOTE: Authority cited: Sections 735.5(c) and 1211(*l*), Insurance Code. Reference: Section 1211, Insurance Code.

HISTORY

1. New section filed 12–19–2006; operative 1–18–2007 (Register 2006, No. 51).

§ 2690.94. Conflict of Interest and Disclosure of Affiliation Form.

COMPANY (COMPANIES) _____

Examination Period _____

Investment Consultant: _____

1. Does the Investment Consultant have a written policy to define conflicts of interest and a process in place to check for and detect actual or potential conflicts of interest?

   If yes, please describe the process in detail:

2. Does the Investment Consultant, or any employee of the Investment Consultant who is assigned to the examination of the COMPANY, have a direct or indirect investment in the COMPANY, or did the Investment Consultant or any employee of Investment Consultant assigned to the examination of the COMPANY have a direct or indirect investment in the COMPANY within the last 12 months or during the period of time for which the examination will apply?

   If yes, please explain:

3. Does the Investment Consultant have a direct or indirect affiliation with the COMPANY, or did the Investment Consultant have a direct or indirect affiliation with the COMPANY within the last 12 months or during the period of time for which the examination will apply?

   If yes, please explain:

4. Has the Investment Consultant, or any employee of the Investment Consultant who is assigned to the examination of the COMPANY, performed any services and/or received any income from the COMPANY within the last 12 months or during the period of time for which the examination will apply?

   If yes, please explain:

5. Does the Investment Consultant, or any employee of the Investment Consultant who is assigned to the examination of the COMPANY, hold any current position with the COMPANY, or has the Investment Consultant, or any employee of the Investment Con-

sultant who is assigned to the examination of the COMPANY, held any position with the COMPANY within the last 12 months or during the period of time for which the examination will apply?

If yes, please explain:

6. Does the Investment Consultant, or any employee of the Investment Consultant who is assigned to the examination of the COMPANY, have any financial relationship with the COMPANY, or did the Investment Consultant, or any employee of the Investment Consultant assigned to the examination of the COMPANY, have any financial relationship with the Company within the last 12 months or during the period of time for which the examination will apply?

If yes, please explain:

7. Has the Investment Consultant, or any employee of the Investment Consultant who is assigned to the examination of the COMPANY, received any gifts, compensation, services, or any other thing of monetary value from the COMPANY within the last 12 months or during the period of time for which the examination will apply?

If yes, please list the items and explain:

8. Was the Investment Consultant, or any employee of the Investment Consultant who is assigned to the examination of the COMPANY, involved in any way with the investments that are the subject of this examination?

If yes, please explain:

9. Does the Investment Consultant have any potential engagements or contracts that are currently being considered which would result in an affirmative response to any of the questions above?

If yes, please explain.

Circle one attestation clause as appropriate:

I have used all reasonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein is true and complete.

OR

I _____ (name of Officer), hereby represent and warrant that I am authorized to complete this Conflict of Interest and Disclosure of Affiliation Form on behalf of _____ (name of company). I do so in my capacity as _____ (title of Officer).

_____ _____

Investment Consultant Date

Reviewed by:

_____ _____

Department of Insurance Date

NOTE: Authority cited: Section 1211(*l*), Insurance Code. Reference: Section 1211, Insurance Code; and California Code of Regulations, Title 2, Chapter 7, Sections 18703.1 and 18703.4.

HISTORY

1. New section filed 12–19–2006; operative 1–18–2007 (Register 2006, No. 51).

Subchapter 7. Insurance Adjusters

Article 1. Classification of Licensees

§ 2691. Classes.

Licenses shall be classified according to the nature of the business entity and according to the general or usual nature of the business conducted, or to be conducted, determined by the usual clientele of the licensee.

(a) Classes, according to the nature of the business entity are:

(1) Individual;

(2) Partnership;

(3) Corporation;

(4) Unincorporated association.

Unincorporated associations include all associations other than partnerships and corporations and shall not be licensed unless each member or associate thereof is licensed in the same capacity.

(b) Licenses classified by the nature of business are the following:

(1) Independent adjusters, which are those licensees principally engaged by insurance companies;

(2) Public adjusters, which are those licensees principally engaged by insured persons.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Section 14024, Insurance Code.

HISTORY

1. New Subchapter 7 (Articles 1–10, Sections 2691 and 2691.1—2691.24) filed 2–11–82; effective thirtieth day thereafter (Register 82, No. 7).

[The next page is 751.]

Article 2. License Applications

§ 2691.1. Change in Legal Entity.

A change in the organization of a licensee which results in a legal entity other than the one licensed requires the filing of an original license application for the new legal entity, and for such branch office licenses as may be applicable, and payment of the fee required for such original license and branch office licenses.

NOTE: Authority cited: Section 14013 (c) and 14097 (e), Insurance Code. Reference: Section 14013 (c) and 14027, Insurance Code.

§ 2691.2. Disclosure of Ten Percent Ownership Interest.

Every application for a license shall disclose, in addition to those matters required by statute, the full name and residence address of each person who directly or indirectly owns, controls, holds with power to vote, or holds proxies representing, ten percent or more of the voting securities of the licensee.

NOTE: Authority cited: Section 14013, 14023, 14024 (h) and14025 (d), Insurance Code. Reference: Sections 14029 (b)(2) and 14039 (a) and (c), Insurance Code.

§ 2691.3. Ten Percent Owners Must Meet Certain Qualifications.

The Commissioner may, in addition to other grounds set forth in the Insurance Code, deny an application or suspend or revoke the license, if a person who directly or indirectly owns, controls, holds with power to vote, or holds proxies representing ten percent or more of the voting securities of the applicant or licensee does not meet the qualifications for such license which are set forth in Insurance Code Sections 14028 and 14061.

NOTE: Authority cited: Section 14013, 14025 (d), Insurance Code. Reference: Sections 14028 and 14061, Insurance Code.

§ 2691.4. Qualifications and Experience.

(a) Applicants for an insurance adjusters license must possess the qualifications required by Section 14025 at the time the application is filed.

(b) One year of experience shall consist of not less than 2,000 hours of actual compensated work performed by each applicant preceding the filing of the application. Applicants shall substantiate claimed years and hours of qualifying experience and the exact details as to the character and nature thereof by written certifications from employers, subject to independent verification by the Commissioner. In the event of inability of applicants to supply such written certifications from employers in whole or in part, applicants may offer written certifications from other than employers to substantiate claimed qualifying experience for consideration by the Commissioner.

NOTE: Authority cited: Section 14013 (a), 14025, Insurance Code. Reference: Section 14025, Insurance Code.

Article 3. License Examinations

§ 2691.5. Complete Application Required.

An applicant for a license as an insurance adjuster is not eligible for examination or re–examination until he has filed a complete application accompanied by the appropriate fee.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Section 14023, 14027, and 14097, Insurance Code.

§ 2691.6. Time and Place of Examination.

(a) The Commissioner will give qualifying examinations to insurance adjuster applicants at least once each month in each of the cities in which he has an office. He may give such examinations at more frequent intervals or in other places throughout the State.

(b) At a reasonable time before an applicant is required to appear for a qualifying examination, the Commissioner will send written notice thereof. Such notice will set forth the time and place of such examination.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Section 14026, Insurance Code.

§ 2691.7. Written Examination Required.

Every qualifying examination for an insurance adjuster's license shall be in writing and shall be of sufficient scope to satisfy the Commissioner that the applicant has sufficient knowledge of and is reasonably familiar with the insurance laws of this State and with the provisions, terms and conditions of the insurance contracts for which settlement of claims may be made pursuant to the license sought, and has a general and fair understanding of the obligations and duties of the holder of such license.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Section 14029, Insurance Code.

§ 2691.8. Failure of Examination.

(a) If the applicant fails the qualifying examination, the Commissioner shall give written notice of such failure and the applicant may retake such qualifying examination, upon filing the appropriate application and fee therefore and taking such examination within the period prescribed in Section 2691.9.

(b) If the applicant fails to appear at the time and place set for the examination the applicant shall be deemed to have failed the examination.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Section 14097, Insurance Code.

§ 2691.9. Automatic Denial of Application After One Year.

If an applicant fails to complete the application or fails to take and pass the examination, nor fails to fully qualify for or receive such license within one year after filing the application, the application is automatically denied without prejudice to the filing of a new application for such license. This section shall not apply when the application has been formally denied nor when a Statement of Issues is pending against the license application.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Section 14023, Insurance Code.

Article 4. Continuation of License Pending Qualification of New Manager

§ 2691.10. Notice of Separation of Qualifying Person.

When the manger or person on the basis of whose qualifications a license as an insurance adjuster has been obtained ceases to be connected with the licensee, the licensee shall notify the Commissioner, in writing, within 30 days from such cessation. If the licensee fails to notify the Commissioner within the 30 day period, the license is automatically suspended at the end of such 30 day period and may be reinstated only upon the filing of an application for reinstatement, payment of renewal fees and delinquency fees due, if any, and the qualification of an individual as provided in Insurance Code Sections 14025 or 14029 (b).

NOTE: Authority cited: Section 14029 (c) and 14030, Insurance Code. Reference: Section 14025, 14029 (c), 14030 and 14035, Insurance Code.

§ 2691.11. Continuation of Business upon Notice.

If notice is given in accordance with Section 2691.10 within 30 days of such cessation, the license shall remain in force, pending the qualification of a manager, for not more than 60 days from the date the previous manager ceased to be connected with the licensee.

NOTE: Authority cited: Section 14030, Insurance Code. Reference: Section 14030, Insurance Code.

Article 5. Information About Employees

§ 2691.12. List of Employees.

Every applicant for a new or renewal license shall file with such application a list of the full names of all employees who are authorized to negotiate claim settlements, and every licensee shall inform the Commissioner in writing within 30 days from the date of the occurrence of the name of any employee hired or terminated subsequent to the filing of the initial list.

NOTE: Authority cited: Sections 14013 (b) and 14041, Insurance Code. Reference: Section 14041, Insurance Code.

Article 6. Branch Office Requirements

§ 2691.13. Branch Office Under Control of Designated Person.

A branch office shall be under the active management, direction and control of the licensee or his manager, with a designated person in charge of such branch office. The licensee shall report to the Commissioner the name of each person appointed as branch office manager within 10 days of such appointment.

NOTE: Authority cited: Sections 14013 (b) and 14041 and 14045, Insurance Code. Reference: Sections 14038 (h), 14041 and 14045, Insurance Code.

§ 2691.14. Records.

A copy of all records relating to claims or loss adjusted or investigated and all activities in connection with investigating, adjusting, appraising or otherwise participating in the disposal, settlement, or investigation of any claim under or in connection with a policy of insurance or any other activity set forth in Insurance Code Section 14021, shall be maintained at and shall be available for inspection by the Department of Insurance at the location from which the business was conducted or transacted for at least five years from the date such business was conducted or transacted. Personnel and financial records may be maintained at the principal office of the licensee but must be furnished to the Commissioner within ten days of his request for production of such records.

NOTE: Authority cited: Section 14045, Insurance Code. Reference: Section 14045, Insurance Code.

§ 2691.15. Branch Office Must Be a Bonafide Place of Business.

A branch office must be a bonafide place of business maintaining reasonable hours for service to customers. A telephone answering service or mail service at any office or location which is not under the active direction, control, charge and management of the licensee or the licensee's manager does not qualify as a branch office.

NOTE: Authority cited: Section 14013 (b), Insurance Code. Reference: Section 14045, Insurance Code.

§ 2691.16. Branch Office Application Required.

An application to conduct business from any location other than the principal place of business shall be submitted on a form prescribed by the Commissioner and accompanied by the prescribed fee.

NOTE: Authority cited: Sections 14023, 14024, 14045, Insurance Code. Reference: Sections 14090, 14091, 14093 and 14094, Insurance Code.

Article 7. Advertisements

§ 2691.17. Advertisement Defined.

(a) The word "advertisement" as used in Section 14044 means:

(1) Any written or printed communication for the purpose of soliciting, describing, or promoting the licensed business of the licensee, including a brochure, letter, pamphlet, newspaper, periodical, publication, or other writing.

(2) A directory listing caused or permitted by the licensee which indicates his licensed activity.

(3) A radio, television or similar airwaves transmission which solicits or promotes the licensed business of the licensee.

(b) The word "advertisement" as used in Section 14044 shall not include the following:

(1) Any printing or writing on buildings used as the licensee's place of business or branch office.

(2) Any printing or writing on communications, memorandum, or any other writings used in the ordinary course of business, where the purpose of the writing is other than the solicitation or promotion of business.

(3) Any printing or writing on novelty objects used in the promotion of the licensee's business where the printing of the information required by Section 14044 will be impractical due to the limited area or surface available.

NOTE: Authority cited: Section 14044, Insurance Code. Reference: Section 14044, Insurance Code.

Article 8. Substantial Relationship Criteria for Crimes of Wrongful Acts

§ 2691.18. Substantial Relationship Criteria.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Sections 14025, 14028 and 14061, Insurance Code.

HISTORY

1. Repealer of article 8 (section 2691.18) and section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

Article 9. Criteria for Evaluating Rehabilitation

§ 2691.19. Evaluation of Rehabilitation.

NOTE: Authority cited: Section 14013, Insurance Code. Reference: Sections 14028 (a), 14029 (b) (2), 14035, 14061 (k), Insurance Code; and Sections 480 and 482, Business and Professions Code.

HISTORY

1. Repealer of article 9 (section 2691.19) and section filed 1–23–2007; operative 2–22–2007 (Register 2007, No. 4).

Article 10. Fees

§ 2691.20. Change of Classification.

The fee for making a change in a license from one classification to another is the same as for an original license to do business under the new classification.

NOTE: Authority cited: Sections 14013(c) and 14097 (e), Insurance Code. Reference: Sections 14013 (a) (c) and 14097 (e), Insurance Code.

§ 2691.21. Renewal Fees.

(a) The renewal fee for a license as an insurance adjuster shall be one hundred dollars.

(b) The renewal fee for a branch office certificate shall be twenty dollars.

(c) There shall be no additional fee charged solely by reason of the classification of a license.

NOTE: Authority cited: Sections 14097 (d) (1), (2) and (e) and 14013(c), Insurance Code. Reference: Sections 14097 (d) (1), (2) and (e) and 14013 (c), Insurance Code.

§ 2691.22. Partnership, Corporation or Unincorporated Association

Before a partnership, corporation or unincorporated association license may be granted, each partner of a partnership, each officer of a corporation, and each member of an unincorporated association, shall file a separate application for such license on the form prescribed by the Commissioner. However, only one officer or partner or manager is required to meet the qualification requirements of Insurance Code Section 14025 in order to qualify for a partnership or corporation license. A separate application fee is required for every partner, officer, or member who is a person named to operate or manage the business of the licensee under the requirements of Insurance Code Sections 14025 and 14029.

NOTE: Authority cited: Sections 14013 (b) and 14025 (d), Insurance Code. Reference: Sections 14029, 14035 and 14097, Insurance Code.

§ 2691.23. Duplicate Copies of License or Identification Card.

The fee for a duplicate copy of an insurance adjuster's license, branch office certificate, or identification card is ten dollars ($10.00).

NOTE: Authority cited: Section 14013 (b), Insurance Code. Reference: Section 12973.7, Insurance Code.

HISTORY

1. Editorial correction of printing error (Register 93, No. 13).

§ 2691.24. No Refunds of Fees.

Application fees, renewal fees, branch office fees or any other fees provided for by statute or regulation shall not be refunded whether or not a license is granted or the examination taken, except under the provisions of Insurance Code Section 12977.

NOTE: Authority cited: Sections 14013 and 14097, Insurance Code; and Section 158, Business and Professions Code. Reference: Sections 14097 and 14099, Insurance Code.

Subchapter 7.4. Consumer Complaints

§ 2694. Criteria for Determining Whether a Consumer Complaint Is Justified.

(a) A consumer complaint shall be deemed justified within the meaning of California Insurance Code section 12921.1(b) where it meets any one or more of the following criteria:

(1) the Department determines that the licensee's act, acts, omission or omissions were in noncompliance with a specific provision or provisions of the California Insurance Code, California Code of Regulations, or other applicable laws and/or regulations;

(2) the Department determines that the licensee's act, acts, omission or omissions were in contravention of an approved rate filing or filings;

(3) the Department determines that the licensee's act, acts, omission or omissions were in contravention of the licensee's rules, policies, procedures or guidelines as relates to sales, marketing, advertising, underwriting, rating, claims and/or customer service, including rate manual filings, underwriting guidelines and/or other filings, statements or guidelines either submitted to the Department or to which the Department would have access during a market conduct examination and the Department determines that there was no substantial justification for deviation from such rules, policies, procedures or guidelines on the facts presented. For purposes of this subsection, all time restrictions or requirements for reply, response, or other legally required insurer action, shall be measured as against applicable time restrictions or parameters established in the California Insurance Code, California Code of Regulations, or other applicable laws and/or regulations.

(4) the Department determines that the licensee's act, acts, omission or omissions were in contravention of, or were otherwise inconsistent with, a provision or provisions of the insurance policy, contract, bond, or other agreement entered into by the relevant parties;

(5) the Department determines that after receiving a written or documented oral communication related to a claim, benefit underwriting or rating transaction, from a policyholder, insured, applicant, third party claimant, beneficiary, principal, or other party with a legitimate interest in the transaction, where that communication reasonably suggests that a response is expected, the licensee has failed to respond or did not provide a complete response, based on the facts then known by the licensee, within the applicable time restrictions established in the California Insurance Code, California Code of Regulations, other applicable laws and/or regulations or, in the absence of such restrictions, the licensee fails to respond within 15 days. A complete response is defined as one that addresses all issues raised and includes copies of any documentation needed to support the licensee's position.

(6) the Department determines that the specific facts surrounding the complaint as against an insurer merit remedial action within the authority of the Commissioner.

NOTE: Authority cited: Section 12921.1(b), California Insurance Code. Reference: Sections 12921, 12921.1, 12921.3 and 12921.4, California Insurance Code.

HISTORY

1. New subchapter 7.4 (section 2694) and section filed 3–11–98; *operative* 3–11–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 11).

Subchapter 7.5. Unfair or Deceptive Acts or Practices in the Business of Insurance

Article 1. Fair Claims Settlement Practices Regulations

§ 2695.1. Preamble.

(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:

(1) To delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);

(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;

(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and,

(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices. Other methods, act(s), or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices and subject to California Insurance Code Section 790.03(h) and/or California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of all claims subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790, except as specifically provided below:

(1) Workers' compensation insurance;

(2) Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);

(3) Self insured or self funded plans which are bona fide Employee Retirement Income Security Act ("ERISA") plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;

(4) Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) In recognition of both the unique relationship which exists under a surety bond between the surety, the obligee or beneficiary, and the principal, and the fact that the processing of surety claims is subject to the Unfair Practices Act, beginning with California Insurance Code Section 790, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.

(d) These regulations apply to home protection contracts and home protection companies defined in California Insurance Code Section 12740.

(e) All licensees, as defined in these regulations, shall have thorough knowledge of the regulations contained in this subchapter.

(f) Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.

(g) The California Insurance Code provides the commissioner with access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine if such person is engaged in any unfair or deceptive act or practice. California Insurance Code Section 790.03(h) requires all persons engaged in the business of insurance to effectuate prompt, fair and equitable settlements of claims and to otherwise process claims in a fair and reasonable manner. The Department considers the use of reliable information to be an essential element of the fair and equitable settlement of claims. The fact that information, data or statistical methods used or relied upon by a licensee to process or establish the value of insurance claims is obtained through a third party source shall not absolve the licensee of its legal responsibility to comply with these regulations or to effectuate prompt, fair and equitable settlements of claims. Failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee's claims handling practices may justify a finding that the licensee was in non-compliance with these regulations or other applicable insurance code provisions. Any and all information received pursuant to the Department's request shall be given confidential treatment, as provided in California Insurance Code section 735.5 and California Government Code Section 11180 et seq. When processing or establishing the value of a claim, a licensee shall not be responsible for the accuracy of information provided by a governmental entity, unless the licensee has discovered or been notified of the inaccuracy and has continued to use the information.

NOTE: Authority cited: Sections 790.034, 790.10, 1871.1, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 735.5, 790.03(h) and 12740, Insurance Code; and Section 11180, Government Code.

HISTORY

1. New subchapter 7.5 (sections 2695.1–2695.17) filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Editorial correction of printing error in HISTORY 1. (Register 93, No. 4).
3. Amendment of subchapter heading and subsection (b), new subsections (b)(1)–(b)(4), repealer and new subsection (c), amendment of subsection (d), repealer of subsection (e) and subsection relettering filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
4. Amendment of subchapter heading and new article 1 heading filed 2–13–2001 as an emergency; operative 2–13–2001 (Register 2001, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–13–2001 or emergency language will be repealed by operation of law on the following day.
5. Amendment of subchapter heading and new article 1 heading refiled 6–1–2001 as an emergency; operative 6–13–2001 (Register 2001, No. 22). A Certificate of Compliance must be transmitted to OAL by 10–11–2001 or emergency language will be repealed by operation of law on the following day.
6. Amendment of subchapter heading and new article 1 heading refiled 10–11–2001 as an emergency; operative 10–11–2001 (Register 2001, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–8–2002 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 10–11–2001 order transmitted to OAL 11–14–2001 and filed 12–31–2001 (Register 2002, No. 1).
8. Amendment of section and NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
9. Inclusion of informational note following article heading filed 3–1–2004 (Register 2004, No. 10).
10. Change without regulatory effect filed 8–4–2004 repealing the informational note following article heading; depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*; and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court-approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
11. Amendment of subsection (b), repealer and new subsection (c), new subsection (g) and amendment of NOTE filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.2. Definitions.

As used in these regulations:

(a) "Beneficiary" means:

(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured; or,

(2) for the purpose of surety claims, a person who is within the class of persons intended to benefit from the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "Claims agent" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

(1) an attorney retained by an insurer to defend a claim brought against an insured; or,

(2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "First party claimant" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under

the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "Gross settlement amount" means the amount tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,

(2) the term "life agent" as used in section 32 of the California Insurance Code; or,

(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,

(4) an underwritten title company.

(i) "Insurer" means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non–profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the California Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term "insurer" for purposes of these regulations includes non–admitted insurers, the California FAIR Plan, the California Earthquake Authority, those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, home protection companies as defined under California Insurance Code Section 12740, and any other entity subject to California Insurance Code Section 790.03(h). The term "insurer" shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers.

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non–profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond". For the purposes of these regulations the term insurance policy or policy includes a home protection contract or any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR Plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(*l*) "Knowingly committed" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) "Notice of claim" means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "Proof of claim" means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

(t) "Remedial measures" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;

(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;

(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "Replacement crash part" means a replacement for any of the non-mechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "Third party claimant" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage;

NOTE: Authority cited: Sections 132(d), 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; Section 995.130, Code of Civil Procedure; and Sections 11152 and 11342.2, Government Code. Reference: Sections 31, 32, 101, 106, 675.5(b), (c) and (d), 676.6, 790.03(h) and 10082, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of subsections (a)(2), (g) and (i)–(*l*) and amendment of NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
4. Amendment of subsection (s) filed 6–5–2003; operative 9–3–2003 pursuant to title 10, section 2695.14, California Code of Regulations (Register 2003, No. 23).
5. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
6. Amendment of subsection (s) filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.3. File and Record Documentation.

(a) Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail

that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined;

(b) To assist in such examination all insurers shall:

(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment. This data must be available for all open and closed files for the current year and the four preceding years;

(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and

(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

NOTE: Authority cited: Sections 790.04, 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of subsections (b)(1) and (b)(2) filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of subsection (b)(1) and amendment of NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).

§ 2695.4. Representation of Policy Provisions and Benefits.

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

(b) No insurer shall misrepresent or conceal benefits, coverages, time limits or other provisions of the bond which may apply to the claim presented under a surety bond.

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of reasonable demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542 provided that, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim that contain or are accompanied by language releasing the insurer, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

(g) No insurer shall require a first party claimant or beneficiary to submit duplicative proofs of claim where coverage may exist under more than one policy issued by that insurer.

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h)(1), (3) and (4), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and subsection (a), repealer and new subsection (b), repealer of subsection (f) and subsection relettering filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
4. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
5. Amendment of subsections (b) and (c) filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.5. Duties upon Receipt of Communications.

(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty–one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

(b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

(1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer ex-

cept where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

(2) provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) begin any necessary investigation of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

NOTE: Authority cited: Sections 790.04, 790.10, 12340–12417, inclusive, 12921, 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(2) and (3), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of subsections (d) and (e), repealer of subsection (e)(4) and amendment of NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).

§ 2695.6. Training and Certification.

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety (90) days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding the regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

A licensee shall demonstrate compliance with this subsection by the following methods:

(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands the regulations and any and all amendments thereto;

(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,

(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

(3) where the licensee retains insurance adjusters as defined in California Insurance Code Section 14021, the licensee must provide training to the insurance adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the insurance adjuster may annually certify in writing, under penalty of perjury, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

(4) a copy of the certification required by subsections 2695.6(b)(1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.

(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h)(3), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of subsection (b)(3) filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).

§ 2695.7. Standards for Prompt, Fair and Equitable Settlements.

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to

the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first–party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first–party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(*l*) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set–off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.

NOTE: Authority cited: Sections 553, 554, 790.03(h)(5), 790.03(h)(12), 790.10, 1861.03(a), 10350.10, 10111.2, 11580.2(k), 12340–12417, inclusive, 12921 and 12926, Insurance Code; Sections 11152 and 11342.2, Government Code; *Egan v. Mutual of Omaha Insurance Company* (1979) 24 Cal.3d 809 [169 Cal.Rptr. 691]; *KPFF, Inc. v. California Union Insurance Company* (1997) 56 Cal.App.4th 963 [66 Cal.Rptr.2d 36] (certified for partial publication); and *Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688 [201 Cal.Rptr. 528]. Reference: Section 790.03(h)(2),

(3), (4), (5), (13) and (15) and 1872.4, Insurance Code; Section 6149.5, Business and Professions Code; and Section 550, Penal Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading, section and NOTE filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of section and NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
4. Editorial correction of subsection (b) inserting phrase inadvertently omitted from text approved 4–24–2003; filed 7–8–2003; operative 7–23–2003 (Register 2003, No. 28).
5. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
6. Amendment of subsections (b)(1) and (g)(7) and amendment of NOTE filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.8. Additional Standards Applicable to Automobile Insurance.

(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims.

(1) the words "automobile" and "vehicle" are used synonymously.

(b) In evaluating automobile total loss claims the following standards shall apply:

(1) The insurer may elect a cash settlement that shall be based upon the actual cost of a "comparable automobile" less any deductible provided in the policy. This cash settlement amount shall include all applicable taxes and one–time fees incident to transfer of evidence of ownership of a comparable automobile. This amount shall also include the license fee and other annual fees to be computed based upon the remaining term of the loss vehicle's current registration. This procedure shall apply whether or not a replacement automobile is purchased.

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant's vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle's future resale and/or insured value. The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

(2) A "comparable automobile" is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of the same model type, of a similar body type, with options and mileage similar to the insured vehicle. Newer model year automobiles may not be used as comparable automobiles unless there are not sufficient comparable automobiles of the same model year to make a determination as set forth in Section 2695.8(b)(4), below. In determining the cost of a comparable automobile, the insurer may use either the asking price or actual sale price of that automobile. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer fairly adjusts for such differences. Any adjustments from the cost of a comparable automobile must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claim file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used. The actual cost of a comparable automobile shall not include any deduction for the condition of a loss vehicle unless the documented condition of the loss vehicle is below average for that particular year, make and model of vehicle. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. A comparable automobile must have been available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer. The comparable automobiles used to calculate the cost shall be identified by the vehicle identification number (VIN), the stock or order number of the vehicle from a licensed dealer, or the license plate number of that comparable vehicle if this information is available. The identification shall also include the telephone number (including area code) or street address of the seller of the comparable automobile.

(3) Notwithstanding subsection (2), above, upon approval by the Department of Insurance, an insurer may use private sales data from the Department of Motor Vehicles, or other approved sources, which does not contain the seller's telephone number or street address. Approval by the Department of Insurance shall be contingent on the Department's determination that reasonable steps have been taken to limit the use of private sales data that may be inaccurately reported to the Department of Motor Vehicles, or other approved sources.

(4) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the average cost of two or more such comparable automobiles; or,

(B) when comparable automobiles are not available or were not available in the local market area in the last 90 days, the average of two or more quotations from two or more licensed dealers in the local market area; or,

(C) the cost of a comparable automobile as determined by a computerized automobile valuation service that produces statistically valid fair market values within the local market area; or

(D) if it is not possible to determine the cost of a comparable automobile by using one of the methods described in subsections (b)(3)(A), (b)(3)(B) and (b)(3)(C) of this section, the cost of a comparable automobile shall otherwise be supported by documentation and fully explained to the claimant. Any adjustments to the cost of a comparable automobile shall be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used

(5) In first party automobile total loss claims, the insurer may elect to offer a replacement automobile which is a specified comparable automobile available to the insured with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer's claim file. A replacement automobile must be in as good or better overall condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

(6) Subsection 2695.8(b) applies to the evaluation of third party automobile total loss claims, but does not change existing law with respect to the obligations of an insurer in settling such claims with a third party.

(c) In first party automobile total loss claims, every insurer shall provide notice to the insured at the time the settlement payment is sent or final settlement offer is made that if notified by the insured within thirty–five (35) calendar days after the insured receives the claim payment or final settlement offer that he or she cannot purchase a comparable automobile for the gross settlement amount, the insurer will reopen its claim

file. If subsequently notified by the insured the insurer shall reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(4). Any such vehicle must be available in the local market area; or,

(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,

(3) The insurer shall invoke the appraisal provision of the insurance policy.

(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

(A) the vehicle identification number (VIN) or,

(B) the stock or order number of the vehicle from a licensed dealer, or

(C) the license plate number of such comparable vehicle.

(d) No insurer shall, where liability and damages are reasonably clear, recommend that the third party claimant make a claim under his or her own policy to avoid paying the claim under the policy issued by that insurer.

(e) No insurer shall:

(1) require that an automobile be repaired at a specific repair shop; or,

(2) suggest or recommend that an automobile be repaired at a specific repair shop, unless all of the requirements set forth in California Insurance Code Section 758.5 have been met.

(3) require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(f) If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be of an amount which will allow for repairs to be made in a workmanlike manner. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between the written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair shop that will make the repairs for the amount of the insurer's written estimate. The insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by law. The insurer shall maintain documentation of all such communications; or,

(3) reasonably adjust any written estimates prepared by the repair shop of the claimant's choice and provide a copy of the adjusted estimate to the claimant.

(g) No insurer shall require the use of non–original equipment manufacture replacement crash parts in the repair of an automobile unless:

(1) the parts are at least equal to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;

(2) insurers specifying the use of non–original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to effect the repair; and,

(3) insurers specifying the use of non–original equipment manufacture replacement crash parts warrant that such parts are of like kind, quality, safety, fit, and performance as original equipment manufacturer replacement crash parts; and,

(4) all original and non–original manufacture replacement crash parts, manufactured after the effective date of this subchapter, when supplied by repair shops shall carry sufficient permanent, non–removable identification so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation; and,

(5) the use of non–original equipment manufacturer replacement crash parts is disclosed in accordance with section 9875 of the California Business and Professions Code.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

(i) When the amount claimed is adjusted because of betterment or depreciation, all justification shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment or depreciation. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. The basis for any adjustment shall be fully explained to the claimant in writing and shall:

(1) reflect a measurable difference in market value attributable to the condition and age of the vehicle, and

(2) apply only to parts normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

(j) In a first party partial loss claim, the expense of labor necessary to repair or replace the damage is not subject to depreciation or betterment unless the insurance contract contains a clear and unambiguous provision permitting the depreciation of the expense of labor.

(k) After a covered loss under a policy of automobile collision coverage or automobile physical damage coverage as defined in California Insurance Code Section 660, where towing and storage are reasonably necessary to protect the vehicle from further loss, the insurer shall pay reasonable towing and storage charges incurred by the claimant. The insurer shall provide reasonable notice to the claimant before terminating payment for storage charges, so that the claimant has time to remove the vehicle from storage. This subsection shall also apply to a third party claim filed under automobile liability coverage as defined in California Insurance Code section 660, however, payment to a third party claimant may be prorated based upon the comparative fault of the parties.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; Section 3333, Civil Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 758.5, 790.03(c) and 790.03(h)(3), Insurance Code; and Section 9875, Business and Professions Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Editorial correction of subsection (i) (Register 95, No. 42).
3. Amendment of section heading and section filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
4. Amendment of section and NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
5. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
6. Change without regulatory effect amending subsection (b) filed 9–15–2004 pursuant to section 100, title 1, California Code of Regulations (Register 2004, No. 38).
7. Amendment of section and NOTE filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).
8. Change without regulatory effect amending subsection (b)(2) filed 3–23–2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 12).

§ 2695.85. Auto Body Repair Consumer Bill of Rights.

(a) Every insurer that issues automobile liability or collision insurance policies shall provide the named insured(s) with an Auto Body Repair

Consumer Bill of Rights either at the time of application for an automobile insurance policy, at the time a policy is issued, or following an accident or loss that is reported to the insurer. If the insurer provides the insured with an electronic copy of a policy, the bill of rights may also be transmitted electronically. If the insurer provides the bill of rights following an accident or loss, the insurer shall also provide the bill of rights to the particular insured filing the insurance claim. If the insurer provides the bill of rights at the time of application or policy issuance, all named insureds that have not previously received the bill of rights shall be provided with a copy upon renewal of the policy.

(b) The requirements set forth in subsection 2695.85(a), above, shall apply to all automobile liability and collision insurance policies issued in California including commercial automobile, private passenger automobile, and motorcycle insurance policies.

(c) The Auto Body Repair Consumer Bill of Rights shall be a separate standardized document and plainly printed in no less than ten-point type. An insurer may distribute the form using its own letterhead, but the language of the Auto Body Repair Consumer Bill of Rights shall be developed by the California Department of Insurance and shall read as follows:

AUTO BODY REPAIR CONSUMER BILL OF RIGHTS

A CONSUMER IS ENTITLED TO:

1. SELECT THE AUTO BODY REPAIR SHOP TO REPAIR AUTO BODY DAMAGE COVERED BY THE INSURANCE COMPANY. AN INSURANCE COMPANY SHALL NOT REQUIRE THE REPAIRS TO BE DONE AT A SPECIFIC AUTO BODY REPAIR SHOP.

2. AN ITEMIZED WRITTEN ESTIMATE FOR AUTO BODY REPAIRS AND, UPON COMPLETION OF REPAIRS, A DETAILED INVOICE. THE ESTIMATE AND THE INVOICE MUST INCLUDE AN ITEMIZED LIST OF PARTS AND LABOR ALONG WITH THE TOTAL PRICE FOR THE WORK PERFORMED. THE ESTIMATE AND INVOICE MUST ALSO IDENTIFY ALL PARTS AS NEW, USED, AFTERMARKET, RECONDITIONED, OR REBUILT.

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES.

4. BE INFORMED ABOUT THE EXTENT OF COVERAGE, IF ANY, FOR A REPLACEMENT RENTAL VEHICLE WHILE A DAMAGED VEHICLE IS BEING REPAIRED.

5. BE INFORMED OF WHERE TO REPORT SUSPECTED FRAUD OR OTHER COMPLAINTS AND CONCERNS ABOUT AUTO BODY REPAIRS.

COMPLAINTS WITHIN THE JURISDICTION OF THE BUREAU OF AUTOMOTIVE REPAIR

Complaints concerning the repair of a vehicle by an auto body repair shop should be directed to:

Toll Free (800) 952-5210

California Department of Consumer Affairs
Bureau of Automotive Repair
10240 Systems Parkway
Sacramento, CA 95827

The Bureau of Automotive Repair can also accept complaints over its web site at: www.autorepair.ca.gov

COMPLAINTS WITHIN THE JURISDICTION OF THE CALIFORNIA INSURANCE COMMISSIONER

Any concerns regarding how an auto insurance claim is being handled should be submitted to the California Department of Insurance at:

(800) 927-HELP or (213) 897-8921

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013

The California Department of Insurance can also accept complaints over its web site at: www.insurance.ca.gov

NOTE: Authority cited: Sections 790.10, 1874.85 and 1874.87, Insurance Code. Reference: Sections 790.03(c), 790.03(h)(3) and 1874.87, Insurance Code; Sections 9884.8 and 9884.9, Business and Professions Code; and California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Section 2695.8(j).

HISTORY

1. New section filed 4-24-2003; operative 7-23-2003 (Register 2003, No. 17).
2. Change without regulatory effect filed 8-4-2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4-24-2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4-24-2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court-approved settlement agreement dated 6-7-2004 (Register 2004, No. 32).

§ 2695.9. Additional Standards Applicable to First Party Residential and Commercial Property Insurance Policies.

(a) When a residential or commercial property insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

(b) No insurer shall require that the insured have the property repaired by a specific individual or entity.

(c) No insurer shall suggest or recommend that the insured have the property repaired by a specific individual or entity unless:

(1) the referral is expressly requested by the claimant; or

(2) the claimant has been informed in writing of the right to select a repair individual or entity and, if the claimant accepts the suggestion or recommendation, the insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and repaired in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations.

(d) If losses are settled on the basis of a written scope and/or estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of each document upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction. The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of costs in the local market area. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between its written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair individual or entity that will make the repairs for the amount of the written estimate. The insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and which will allow for repairs in a manner which meets accepted

trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations; or,

(3) reasonably adjust any written estimates prepared by the repair individual or entity of the insured's choice and provide a copy of the adjusted estimate to the claimant.

(e) Once the appraisal provision under an insurance policy is invoked, the appraisal process shall not include any legal proceeding or procedure not specified under California Insurance Code Section 2071. Nothing herein is intended to preclude separate legal proceedings on issues unrelated to the appraisal process.

(f) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification for the adjustment shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. Any adjustments for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property and apply only to property normally subject to repair and replacement during the useful life of the property. The basis for any adjustment shall be fully explained to the claimant in writing.

(1) Under a policy, subject to California Insurance Code Section 2071, where the insurer is required to pay the expense of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality, the measure of recovery is determined by the actual cash value of the damaged or destroyed property, as set forth in California Insurance Code Section 2051. Except for the intrinsic labor costs that are included in the cost of manufactured materials or goods, the expense of labor necessary to repair, rebuild or replace covered property is not a component of physical depreciation and shall not be subject to depreciation or betterment.

NOTE: Authority cited: Sections 790.10, 2051, 2051.5, 2071, 12921 and 12926, Insurance Code; Section 7109, Business and Professions Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h)(3), (5) and (7), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading and section filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of section heading, section and NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
4. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
5. Amendment of subsections (c)(2) and (e), new subsections (f)–(f)(1) and amendment of NOTE filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.10. Additional Standards Applicable to Surety Insurance.

(a) No insurer shall base or vary its claims settlement practices, or its standard of scrutiny and review, upon the claimant's age, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) As soon as possible, but in no event later than forty (40) calendar days after receipt by the insurer of proof of claim, and provided the claim is not in litigation or arbitration, the insurer shall accept or deny the claim, in whole or in part, and affirm or deny liability. Every insurer that denies or rejects a claim in whole or in part, or disputes liability or damages, shall provide to the claimant a written statement listing all bases for such rejection or denial, and the factual and legal bases for each reason given for each rejection or denial, which are within the insurer's knowledge. If an insurer's denial of a claim in whole or in part is based on a specific statute or specific bond provisions, the denial shall include reference thereto and provide an explanation of the application of the statute or bond provision to the claim. Written notification pursuant to this subsection shall also include a notification that the claimant may have the matter reviewed by the California Department of Insurance and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims practices.

(1) A principal's absence, non–cooperation, or failure to meet the bonded obligation shall not excuse unreasonable delay by the insurer in determining whether a claim should be accepted or denied.

(2) While an insurer may consider all information provided by a principal, absent reasonable factual and/or legal bases for denying a claim, no insurer shall deny a claim based solely upon a principal's protest of a claim or denial of liability for a claim.

(c) In the event an insurer requires more time than is allotted in subsection 2695.10(b) to determine whether a claim should be accepted and/or denied, in whole or in part, the insurer shall provide the claimant with written notice of the need for such additional time within the time specified in subsection 2695.10(b). Such written notice shall specify the reasons for the need for such additional time, including specification of any additional information the insurer requires in order to make such determination. The insurer shall provide the claimant with written notice as to the continuing reasons for the insurer's inability to make such a determination. Except in cases where extraordinary circumstances are present which materially affect the insurer's ability to comply, such written notice shall be provided within 30 calendar days of the date of the initial notification, and every 30 calendar days thereafter until such determination is made or notice of legal action is received. If the determination cannot be made until some event, process, or third party determination is made, then the insurer shall comply with this requirement by advising the claimant of the situation and provide an estimate as to when the determination can be made.

(d) No insurer shall fail to pursue diligently an investigation of a claim, or persist in seeking information not reasonably required for or material to resolution of a claim dispute.

(e) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of section 2695.3.

(f) Where the claim is to be settled by payment, and where neither the claim nor the amount is in dispute, such payment shall be tendered (1) within 15 calendar days following affirmation of liability where the insurer does not require the claimant to execute a release, or (2) within 15 calendar days following the insurer's receipt of a release properly executed by the claimant, where such release is required by the insurer. Such release shall be provided to the claimant within ten (10) calendar days following affirmation of liability. Where multiple claimants are involved, payment shall be made pursuant to this subsection, provided such payment shall not increase the insurer's liability, or impair the rights of other claimants under the bond.

(g) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitations or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant no less than sixty (60) days prior to the expiration date. If notice of claim is first received by the insurer within sixty (60) days of the expiration date and such date is known to the insurer, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter or to a claim already time barred when first received by the insurer.

(h) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the procedures used by the insurer in determining the dollar amount of damages;

(4) any other credible evidence presented to the Commissioner that demonstrates that the final amount offered by the insurer in settlement of a claim is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

NOTE: Authority cited: Sections 790.10, 12921, 12921.1 and 12926, Insurance Code. Reference: Sections 790.03(h)(3), (4) and (15) and 12921.3, Insurance Code; and Section 2807, Civil Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Amendment of section heading, repealer and new section, and amendment of NOTE filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of section heading, repealer and new section and amendment of NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
4. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
5. Amendment of subsections (a) and (b) and new subsections (b)(1)–(2) and (g)–(h)(4) filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.11. Additional Standards Applicable to Life and Disability Insurance Claims.

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

(e) When a policy requires preauthorization of non–emergency medical services, the preauthorization must be given immediately but in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(1), (2), (3), (5) and (13) and 10123.13, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Repealer of former section 2695.11 and renumbering and amendment of former section 2695.12 to new section 2695.11 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of section and NOTE filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).

§ 2695.12. Penalties.

(a) In determining whether to assess penalties and if so the appropriate amount to be assessed, the Commissioner shall consider admissible evidence on the following:

(1) the existence of extraordinary circumstances;

(2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the California Insurance Code;

(3) the complexity of the claims involved;

(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;

(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;

(6) secreting of property which has been claimed as lost or destroyed.

(7) the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period;

(8) whether the licensee has taken remedial measures with respect to the noncomplying act(s);

(9) the existence or nonexistence of previous violations by the licensee;

(10) the degree of harm occasioned by the noncompliance;

(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter;

(12) the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter;

(13) whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures; and

(14) the licensee's reasonable mistakes or opinions as to valuation of property, losses or damages.

(b) This section shall not bar, obstruct or restrict any right to administrative due process an insurer may be afforded under California Insurance Code Sections 790.05, 790.06, and 790.07.

NOTE: Authority cited: Sections 704, 780–784, 790.035, 790.07, 790.08, 790.09, 790.10, 1011, 1065, 1872.4, 11690, 12340–12417, inclusive, 12921, 12926 and 12928.6, Insurance Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h), 790.035(a), 790.04, 790.05, 790.06, 790.08 and 790.10, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Renumbering and amendment of former section 2695.12 to new section 2695.11, and renumbering and amendment of former section 2695.14 to new section 2695.12, including amendment of section heading and NOTE, filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Amendment of section heading and section filed 4–24–2003; operative 7–23–2003 (Register 2003, No. 17).
4. Change without regulatory effect filed 8–4–2004 depublishing the amendments to the insurance claims handling practices regulations that were approved by OAL 4–24–2003, but were enjoined in *Personal Insurance Federation and The Surety Association of America v. John Garamendi*, and reinstating replacement regulations that were either (1) in effect prior to OAL's 4–24–2003 approval of the amendments to the regulations or (2) were found by the court to be valid, as amended, all pursuant to a court–approved settlement agreement dated 6–7–2004 (Register 2004, No. 32).
5. Amendment of subsections (a) and (a)(7) and new subsection (b) filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22).

§ 2695.13. Severability.

If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Editorial correction of Authority cite (Register 95, No. 42).
3. Repealer of former section 2695.13 and renumbering of former section 2695.16 to new section 2695.13 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

§ 2695.14. Compliance Date.

(a) Any amendments to these regulations shall be complied with within ninety (90) calendar days after they are filed with the Secretary of State.

(b) Prior to the compliance date of these regulations, licensees shall, pursuant to Section 2695.6, adopt and communicate to their claims agents standards for the prompt investigation and processing of claims, and provide training and instruction on these regulations.

(c) These regulations shall apply to any claims handling that takes place on or after the compliance date set forth under subsection 2695.14(a).

NOTE: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Section 11343.4, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 6–1–2006; operative 8–30–2006 (Register 2006, No. 22). For prior history, see Register 2004, No. 32.

§ 2695.15. Penalties.

NOTE: Authority cited: Sections 790.035, 790.07, 790.08, 790.09, 790.10, 1872.4, 12340–12417, inclusive, 12921, 1065, 704, 780–784, 1011, 11690, 12926 and 12928.6, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h), 790.035(a), 790.04, 790.05, 790.06, 790.08 and 790.10, Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Repealer filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

§ 2695.16. Severability.

NOTE: Authority cited: Sections 790.10, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Renumbering of former section 2695.16 to new section 2695.13 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).

§ 2695.17. Effective Date.

NOTE: Authority cited: Sections 790.10, 11346.2, 12340–12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

HISTORY

1. New section filed 12–15–92; operative 1–14–93 (Register 92, No. 52).
2. Renumbering and amendment of former section 2695.17 to new section 2695.14 filed 1–10–97; operative 5–10–97 (Register 97, No. 2).
3. Editorial correction repealing inadvertently retained text of renumbered section (Register 99, No. 50).

Article 1.5. Sales to Military Personnel

§ 2695.20. Purpose.

The purpose of this article is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair. However, no exemption, exclusion or silence in this article as to any act or practice shall be construed to suggest that such act or practice, when performed or engaged in by an insurer or insurance producer, is not otherwise in violation of underlying statute or other applicable law.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New article 1.5 (sections 2695.20–2695.28) and section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.21. Scope.

With the exception of subdivision (*l*) of Section 2695.24, this article shall apply only to the solicitation or sale of any annuity product or other life insurance by an insurer or insurance producer to an active duty service member of the United States Armed Forces.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.22. Authority.

This article is issued under the express authority of Insurance Code sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.23. Exemptions.

(a) Sections 2695.25, 2695.26 and 2695.27 of this article shall not apply to solicitations or sales involving:

(1) Credit insurance;

(2) Group life insurance (or group annuities) where there is no in–person, face–to–face solicitation of individuals by an insurance producer and the contract or certificate does not include a side fund;

(3) An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by

the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

(4) Individual stand–alone health policies, including disability income policies;

(5) Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. Section 1965 et seq.;

(6) Life insurance contracts offered through or by a nonprofit military association, qualifying under Section 501(c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

(7) Contracts used to fund:

(A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(B) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;

(C) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

(D) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(E) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(F) Prearranged funeral contracts.

(b) Nothing herein shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the United States Armed Forces in accordance with Department of Defense DoD Instruction 1344.07 – PERSONAL COMMERCIAL SOLICITATION ON DOD INSTALLATIONS or any successor directive.

(c) For purposes of this article, general advertisements, direct mail and internet marketing shall not constitute "solicitation." Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation. Provided, however, nothing in this subdivision (c) shall be construed to exempt an insurer or insurance producer from this article in any in–person, face–to–face meeting established as a result of the "solicitation" exemptions identified in this subdivision.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.24. Definitions.

(a) "Active duty" means full–time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full–time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

(b) "Department of Defense (DoD) personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

(c) "Door to door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.

(d) "General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

(e) "Individually issued annuity" means any annuity that neither directly nor indirectly includes, is part of or is attached by rider, endorsement or other mechanism to another life insurance product of any kind.

(f) "Insurer" means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

(g) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

(h) "Known" or "knowingly" means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited is a service member.

(i) "Life insurance" means insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income and, unless otherwise specifically excluded, includes individually issued annuities.

(j) "Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

(k) "MyPay" is a Defense Finance and Accounting Service (DFAS) web–based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

(*l*) As used in this article, in Sections 2534.28, 2542.3 and 2544.2, and in Insurance Code section 10168, "premium deposit fund" means amounts paid in (including any interest credited thereon) and held for payments of future contractual obligations of policyholders or contractholders under an individual life insurance policy (or individual annuity contract). The term does not include paid–in amounts, or interest credited thereon, held for the purchase at a future date of annuity benefits for the policyholder of an individual life insurance policy (or the contractholder of an individual annuity contract).

(m) "Service member" means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.

(n) "Side fund" is defined as a fund or reserve that is part of or otherwise attached to a life insurance policy (which life insurance policy is not an individually issued annuity) by rider, endorsement or other mechanism and which accumulates premium or deposits with interest or by other means. Three exceptions are added to the definition of "side fund" that is stated in the preceding sentence, and these exceptions are described in paragraphs (n)(1), (n)(2) and (n)(3) of this subdivision (n), respectively. For purposes of paragraphs (n)(1) and (n)(2) below, the term "presumptive side fund" means a fund or reserve that, before any of the three exceptions is added, satisfies the definition stated in the first sentence of this subdivision (n).

(1) The following values or guarantees provided by a universal life policy are excepted from the definition of "side fund": accumulated value, cash surrender value or secondary guarantees. However, unless the statement in subparagraph (n)(1)(A) below or the statement in subparagraph (n)(1)(B) below is true, a presumptive side fund constitutes a "side fund," regardless of whether amounts held in such presumptive side fund are taken into account in the method by which accumulated value, cash surrender value or secondary guarantees are calculated:

(A) the presumptive side fund in question is itself nothing other than an accumulated value, cash surrender value or secondary guarantee, each provided by a universal life policy, or

(B) the presumptive side fund in question is pursuant to paragraph (n)(2) below or paragraph (n)(3) below excepted from the definition of "side fund."

(2) Cash surrender values provided by a whole life policy which are subject to Article 3A of Chapter 1 of Part 2 of Division 2, commencing at section 10159.1, of the Insurance Code are excepted from the definition of "side fund." However, unless the statement in subparagraph (n)(2)(A) below or the statement in subparagraph (n)(2)(B) below is true, a presumptive side fund constitutes a "side fund," regardless of whether amounts held in such presumptive side fund are taken into account in the method by which cash surrender values are calculated:

(A) the presumptive side fund in question is itself nothing other than a cash surrender value as described in the first sentence of this paragraph (n)(2), or

(B) the presumptive side fund in question is pursuant to paragraph (n)(1) above or paragraph (n)(3) below excepted from the definition of "side fund."

(3) The following is excepted from the definition of "side fund": a premium deposit fund which:

(A) contains only premiums paid in advance which accumulate at interest;

(B) imposes no penalty for withdrawal;

(C) does not permit funding beyond future required premiums;

(D) is not marketed or intended as an investment; and

(E) does not carry a commission, either paid or calculated.

(o) "Specific appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.

(p) "United States Armed Forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.25. Practices Declared False, Misleading, Deceptive or Unfair on a Military Installation.

(a) The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in–person, face–to–face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

(1) Knowingly soliciting the purchase of any life insurance product "door to door" or without first establishing a specific appointment for each meeting with the prospective purchaser.

(2) Soliciting service members in a group or "mass" audience or in a "captive" audience where attendance is not voluntary.

(3) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(4) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

(5) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(6) Posting unauthorized bulletins, notices or advertisements.

(7) Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(8) Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States Armed Forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the Armed Forces.

(b) The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(2) Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.26. Practices Declared False, Misleading, Deceptive or Unfair Regardless of Location.

(a) The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

(1) Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member's pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member's "MyPay" account or other similar internet or electronic medium for such purposes. This subsection does not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

(2) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

(A) provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 et seq. and the regulations promulgated thereunder; and

(B) permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

(3) Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship as defined in Paragraph (a)(2) of this Section 2695.26.

(4) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

(5) Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel.

(6) Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.

(7) Knowingly offering or giving anything of value to a service member for his or her attendance to any event where an application for life insurance is solicited.

(8) Advising a service member to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

(b) The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

(1) Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor."

Nothing herein shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Master of Science In Financial Services (MSFS), or Masters of Science Financial Planning (MS).

(2) Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, or the United States Armed Forces.

(c) The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

(1) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

(2) Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product "costs nothing" or is "free."

(d) The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive or unfair:

(1) Making any representation regarding the availability, suitability, amount, cost, exclusions or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading or deceptive.

(2) Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive.

(3) Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member's separation from the United States Armed Forces.

(e) The following acts or practices by an insurer and or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

(1) Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.

(2) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in–person, face–to–face meeting with a prospective purchaser.

(3) Excluding individually issued annuities, failing to clearly and conspicuously disclose the fact that the product being sold is life insurance.

(4) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the "Military Personnel Financial Services Protection Act," Pub. L. No. 109–290, p.16 (109 P.L. 290; 120 Stat. 1317).

(5) Excluding individually issued annuities, when the sale is conducted in–person face–to–face with an individual known to be a service member, failing to provide the applicant at the time the application is taken:

(A) an explanation of any free look period with instructions on how to cancel if a policy is issued; and

(B) either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of Chapter 5.5 of Part 2 of Division 2 of the Insurance Code, commencing at section 10109.950, shall be deemed sufficient to meet this requirement for a written disclosure.

(f) The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

(1) Excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable. Offering for sale or selling a life insurance product which includes a side fund to a service member who is currently enrolled in SGLI is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(A) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents.

(B) "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

(2) Excluding individually issued annuities, offering for sale or selling any life insurance contract which includes a side fund unless:

(A) interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(B) the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

(C) funds accumulated in the side fund cannot be diverted or transferred by default to pay, reduce or offset any premiums due.

(3) Excluding individually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, violates Article 3A of Chapter 1 of Part 2 of Division 2, commencing at section 10159.1, or Article 3B of Chapter 1 of Part 2 of Division 2, commencing at section 10168, of the Insurance Code.

(4) Selling any life insurance product to an individual known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service. However, a life insurance product that provides for an increased benefit

(e.g., double indemnity) in the event of accidental death may exclude coverage for such an increase if the insured's death is related to war, declared or undeclared, or any act related to military service, so that when death is so related to war or military service the product will pay an amount equal to the primary coverage amount (and not, for example, twice that amount, as would ordinarily be the case with a product providing for double indemnity in the event of accidental death), even though the cause of death is accident.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.27. Severability.

If any provision of these sections or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these sections which can be given effect without the invalid provisions or application. To this end all provisions of these sections are declared to be severable.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

§ 2695.28. Effective Date.

This article shall become effective upon filing with the Secretary of State and shall apply to acts or practices committed on or after the effective date.

NOTE: Authority cited: Sections 720, 790.10, 10168.92, 10206.5, 10506 and 10506.3, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 32, 101, 330, 331, 332, 333, 334, 350, 351, 358, 359, 360, 700, 730, 733, 780, 781, 783, 783.5, 790.03, 791.02, 791.03, 1626, 10159.1, 10165, 10168, 10206.5, 10506, 10506.3, 10509.8, 10509.9 and 10540, Insurance Code; Section 823.5, Military and Veterans Code.

HISTORY

1. New section filed 2–22–2008; operative 2–22–2008 pursuant to Government Code section 11343.4 (Register 2008, No. 8).

Article 2. Public Inspection and Publication of Examinations of Unfair or Deceptive Practices in the Business of Insurance Regulations

§ 2695.30. Comments of Examined Insurers Relating to Adopted Examination Reports.

(a) Comments submitted by examined insurers in relation to adopted reports of examination of unfair or deceptive practices shall be submitted to the Commissioner in a typewritten or printed format that conforms to the following specifications, and must also be submitted through the use of electronic media calculated to produce an original document. Faxed submissions will not be accepted for posting or inspection.

(1) Comments shall relate directly to the adopted report of examination and shall use "Plain English," so that the meaning of the comments will be easily understood by the public.

(2) Comments shall be submitted in letter form, with the letterhead of the examined insurer or similar identifying information, including the true name of the insurer, appearing prominently at the top of the first page.

(3) Comments shall be submitted on opaque, unglazed paper, white or unbleached, of standard quality not less than 20–pound weight, 8–1/2 by 11 inches in size. The typeface shall be essentially equivalent to Courier, Times, or Helvetica, and the font used shall not be smaller than 12 point. The color of print shall be blue–black or black.

(4) Only one side of the paper shall be used, and the lines on each page shall be one and one–half spaced or double spaced; but footnotes and quotations may be single spaced. The left margin shall be at least one inch from the left edge of the paper and the right margin at least one–half inch from the right edge of the paper. Top and bottom margins shall be no smaller than one–half inch. Each page shall be numbered consecutively at the bottom.

(5) Comments, including appendices, exhibits or other supplemental documents, shall be no longer than twenty (20) pages, or the length of the adopted examination report to which the comments relate, whichever is greater. Each supplemental document shall conform to the specifications of this section.

NOTE: Authority cited: Sections 12921, 12921.7, 12926 and 12938, Insurance Code. Reference: Sections 734.1, 790.03 and 12938, Insurance Code.

HISTORY

1. New article 2 (section 2695.30) and section filed 2–13–2001 as an emergency; operative 2–13–2001 (Register 2001, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–13–2001 or emergency language will be repealed by operation of law on the following day.
2. New article 2 (section 2695.30) and section refiled 6–1–2001 as an emergency; operative 6–13–2001 (Register 2001, No. 22). A Certificate of Compliance must be transmitted to OAL by 10–11–2001 or emergency language will be repealed by operation of law on the following day
3. New article 2 (section 2695.30) and section refiled 10–11–2001 as an emergency; operative 10–11–2001 (Register 2001, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–8–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 10–11–2001 order transmitted to OAL 11–14–2001 and filed 12–31–2001 (Register 2002, No. 1).

Subchapter 7.5.1. Insurance Adjuster Training for Evaluating Earthquake Damage

§ 2695.40. Authority and Purpose.

These regulations are promulgated pursuant to the authority granted to the Insurance Commissioner under the provisions of Insurance Code Section 10089.3. The purpose of these regulations is to set forth standards governing the training of insurance adjusters in evaluating damage caused by earthquakes and the procedures for reporting unaccredited adjusting.

NOTE: Authority cited: Section 10089.3, California Insurance Code. Reference: Section 10089.3, California Insurance Code.

HISTORY

1. New subchapter 7.5.1 (sections 2695.40–2695.45) and section filed 3–25–2004; operative 3–25–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 13).

§ 2695.41. Definitions.

As used in these regulations and in Section 10089.3 of the California Insurance Code.

(a) "Accreditation" means certification that a person has received training that meets the standards set forth in this subchapter.

(b) "Insurance adjuster" or "adjuster" is any person included in California Insurance Code Section 10089.3(b).

(c) "Insurer" means an "admitted" or "nonadmitted" insurer, as defined in California Insurance Code Sections 23, 24 and 25, that issues or delivers a policy of insurance in this state covering the peril of earthquake.

(d) "Training" or "train" means to provide a course of instruction that meets the standards prescribed in Section 2695.42 for those adjusters who evaluate earthquake damage.

NOTE: Authority cited: Section 10089.3, California Insurance Code. Reference: Sections 23, 24, 25 and 10089.3, California Insurance Code.

HISTORY

1. New section filed 3–25–2004; operative 3–25–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 13).

§ 2695.42. Training Standards.

Every insurer shall provide training regarding the handling of earthquake claims to insurance adjusters who evaluate earthquake claims for or on behalf of the insurer. The insurer may provide the training directly or have the training provided by another entity. The insurer shall ensure that the course of instruction meets all requirements set forth in this Section 2695.42. An adjuster trained and accredited by one insurer shall be deemed accredited in order to adjust claims for a different insurer unless such insurer includes additional requirements. The content of the training required by this section shall include the following topics:

(a) The California Fair Claims Settlement Practices Regulations, California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Section 2695.1 – 2696.14, inclusive. Demonstration of compliance with the annual training and certification requirements of 10 CCR 2695.6 shall satisfy an insurance adjuster's training requirements prescribed by this subsection.

(b) Determination of Scope of Loss: Adjusters shall be trained how to conduct a thorough examination of the property to be inspected including but not limited to: attics, crawlspaces, roofs, chimneys, foundations, and structural areas. The adjuster shall be trained how to make a complete listing of all recent earthquake damage. Training pursuant to this subsection shall include building code upgrade issues and procedures to be followed if additional hidden earthquake damage is found after repair of earthquake damage has begun.

(c) Loss Estimation Techniques: Adjusters shall be trained how to create or obtain an accurate estimate of all covered earthquake damage. The adjuster shall be trained regarding the appropriate level of detail to be contained in the estimate and the documentation necessary to support the estimate. Adjusters shall be trained to reevaluate the estimate if the actual costs of repair differ from the costs listed on the original estimate.

(d) Determination of Necessity for Engineer or Expert: Adjusters shall be trained how to evaluate visible damage and indicia of hidden damage to determine when to consult with an engineer or other expert.

(e) California Department of Insurance Earthquake Mediation Program: Adjusters shall receive training regarding the Earthquake Claims Mediation Program of the California Department of Insurance set forth at California Insurance Code Section 10089.70 and California Code of Regulations, Title 10, Chapter 5, Subchapter 7.6, Sections 2696.1 through 2696.10, inclusive.

(f) Assessment of Damage to Concrete Surfaces and Foundations: Adjusters shall be trained on the basic techniques used to determine the difference between preexisting cracks in the concrete of structures and new cracks caused by an earthquake. Complete training pursuant to this subsection shall include methodology for determining when repair or replacement of the concrete is appropriate and proper methods for concrete repair including, but not limited to injected epoxy methods.

(g) Subsequently Discovered Earthquake Damage: Adjusters shall be trained on the basic requirements of current law regarding the obligation of the insurer to investigate any earthquake damage that is discovered or reported and when it may be appropriate to seek legal counsel to assist in making this determination.

(h) Programs Designed to Assist Earthquake Victims: Adjusters shall be trained regarding the existence of United States Small Business Administration and Federal Emergency Management Agency or other similar programs intended to assist earthquake victims. Training pursuant to this subsection shall include an overview of these programs and deadlines, and how these programs and deadlines interact with the underlying earthquake insurance claim.

NOTE: Authority cited: Section 10089.3, California Insurance Code. Reference: Sections 790.03(h), 10089.3 and 10089.70, California Insurance Code; and Sections 2695.1–2695.14 and 2696.1–2696.10, Title 10, California Code of Regulations.

HISTORY

1. New section filed 3–25–2004; operative 3–25–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 13).

§ 2695.43. Accreditation.

(a) Certificates shall be provided by the insurer or the training entity to any student successfully completing the adjuster training and shall contain the following information:

(1) name, address and telephone number of the insurer or other entity providing the adjuster training required by this subchapter;

(2) full name of adjuster, and license number if applicable;

(3) a statement certifying that the adjuster completed training that meets the standards set forth in these regulations;

(4) signatures of both adjuster and trainer; and

(5) completion date of training.

(b) Accreditation must be renewed every three years by completing the training required by Subsection 2695.42.

NOTE: Authority cited: Section 10089.3, California Insurance Code. Reference: 10089.3, California Insurance Code.

HISTORY

1. New section filed 3–25–2004; operative 3–25–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 13).

§ 2695.44. Maintenance of Records.

(a) Insurers or other entities providing adjuster training must maintain records of all adjusters completing the program, for a period of five years. An insurer using an adjuster to evaluate earthquake damage must keep a record of that adjuster's accreditation for a period of five years. These records must contain the following information:

(1) name of adjuster and license number if applicable;

(2) date training completed;

(3) name, address and telephone number of training entity.

NOTE: Authority cited: Section 10089.3, California Insurance Code. Reference: Section 10089.3, California Insurance Code.

HISTORY

1. New section filed 3–25–2004; operative 3–25–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 13).

§ 2695.45. Reporting Requirements for Unaccredited Adjusters.

(a) An insurer using one of more adjusters to evaluate damage caused by earthquakes who are not trained and accredited in accordance with the standards set forth in this subchapter shall comply with the following requirements:

(1) annually submit a list of those adjusters who have not completed the training to the Department of Insurance. Each list of adjusters shall include the name of the adjuster, license number (if any), and claim number of the earthquake claim evaluated by that adjuster; and

(2) each list of adjusters described above must be submitted to the Department of Insurance within 30 calendar days from the end of the reporting period and shall cover the preceding twelve–month period. The initial reporting period begins January 1, 2005 and ends December 31, 2005.

NOTE: Authority cited: Section 10089.3, California Insurance Code. Reference: Section 10089.3, California Insurance Code.

HISTORY

1. New section filed 3–25–2004; operative 3–25–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 13).

Subchapter 7.6. Insurance Mediation Program

§ 2696.1. Purpose.

The purpose of these regulations is to interpret, clarify and make specific the Department's program relating to the mediation of earthquake, homeowners and automobile collision and physical damage claims pursuant to Insurance Code section 10089.70.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.70 and 10089.83, Insurance Code.

HISTORY

1. New subchapter 7.6 (sections 2696.1 through 2696.10) and section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Com-

pliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.

2. Subchapter 7.6 (sections 2696.1–2696.10) and section repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New subchapter 7.6 (sections 2696.1–2696.10) and section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Amendment of subchapter heading, section and NOTE filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.2. Definitions.

For the purposes of these regulations:

(a) "Residential Coverage" means insurance coverage for individually owned:

(1) One to four family dwellings, used exclusively for residential purposes; or,

(2) Manufactured homes, used exclusively for residential purposes; or,

(3) A single family unit within a row house, town house, condominium, planned unit development, or cooperative and used exclusively for residential purposes; or,

(4) Tenant residences located within any residential unit;

(b) "Question of major insurance coverage" shall mean the core determination of whether earthquake, residential property, or automobile collision or physical damage insurance coverage is or is not in dispute. All disputes relating to canceled or non–renewed policies, non–mandated building code upgrades, and claims for damage where there is no underlying coverage involve a question of major insurance coverage and will not be referred to mediation. Disputes including, but not limited to, scope of damage, scope or method of repairs, cause of damage, asbestos or other contaminations, additional living expenses, aftershock damage and disputes over preexisting damage do not concern a question of major insurance coverage and are eligible for referral to mediation;

(c) "Purely legal interpretation" means where the resolution of the dispute rests solely upon interpretation of law, including but not limited to statutes, regulations or case law. All disputes including but not limited to statutes of limitation, contractual deadlines, and allegations of bad faith, the resolution of which involves only a question of law, fall within a purely legal interpretation and will not be referred to mediation. Disputes including, but not limited to, questions of fact and questions of liability do not involve a purely legal interpretation and are eligible for referral to mediation;

(d) "Disputes involving the action of an agent or broker" means where the insurer is not alleged to have been directly involved in the conduct of an agent or broker;

(e) "Frivolous complaint" means any complaint which includes, but is not limited to, a complaint designed to vex or harass or concerns matters of a wholly trivial nature.

(f) "Disputes in which a party is alleged to have committed fraud" means complaints in which the insurer is actively investigating the claim for fraud, including the insurer's compliance with Insurance Code section 1872.4, and there is no possibility of resolving the claim until the fraud investigation has been completed.

(g) "Calendar day" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and includes the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(h) "Mediation" means the good faith participation by an insurer and insured, and their representatives, in a non–binding procedure before a neutral third party directed toward the resolution of a pending claim for damages caused by an earthquake or eligible homeowners, automobile collision, or automobile physical damage loss under a policy of insurance.

(i) "Policy" means the written contract between an insured and an insurance company stating the obligations and responsibilities of each party. A policy may include any applications, binders, declaration forms, endorsements, certificates, and any other documents which describe, affect or limit coverage under the policy;

(j) "Business day" means each and every day except Saturdays, Sundays, Federal and California State Holidays;

(k) "In writing", as referenced in this subchapter, includes transmission by facsimile (fax).

(*l*) "Homeowners" means insurance that covers:

(1) Loss of or damage to real property which is used predominantly for residential purposes and which consists of not more than four dwelling units.

(2) Loss of or damage to personal property in which natural persons resident in specifically described real property of the kind described in paragraph (1) have an insurable interest, except personal property used in the conduct of a commercial or industrial enterprise.

(m) An eligible homeowners loss is either a claim that arises under a homeowners insurance policy and that involves a loss due to a fire for which the Governor has declared a state of emergency pursuant to Section 8558 of the Government Code; or a claim that arises under a policy covering earthquake damage and involves loss due to an earthquake for which the Governor has declared a state of emergency pursuant to Section 8558 of the Government Code.

(n) An eligible automobile collision or automobile physical damage claim is a claim that arises under automobile collision coverage or automobile physical damage coverage, in a policy as defined in Section 660 of the Insurance Code.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 660, 675, 10089.7, 10089.70 and 10089.83, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of subsection (c) (Register 97, No. 33).
5. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
6. Amendment of subsections (b) and (h), new subsections (*l*)–(n) and amendment of NOTE filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

[The next page is 752.3.]

§ 2696.3. Determination of Eligibility.

(a) The following will not be referred to mediation under this subchapter:

(1) Disputes that turn on a question of major insurance coverage as that term is defined in Section 2696.2(b) of this subchapter;

(2) Disputes involving a purely legal interpretation as that term is defined in Section 2696.2(c) of this subchapter;

(3) Disputes involving the actions or conduct of an agent or broker, unless there are allegations that the insurer is responsible for the actions or conduct;

(4) Disputes in which a party is alleged to have committed fraud as defined in Section 2696.2(f) of this subchapter;

(5) Disputes involving allegations of bad faith, or other claims for extra contractual damages;

(6) Disputes concerning which a lawsuit has already been filed;

(7) Those requests for mediation determined by the Department to be frivolous or to have been filed in bad faith.

(b) Notwithstanding subsection (a), should a claim involve more than one disputed issue and one or more of those issues are not eligible for referral to mediation, nothing in this subchapter shall preclude the commissioner from referring to mediation only those issues eligible for mediation. However, the Commissioner shall not refer to mediation those issues which are rendered moot by the determination that a question of major insurance coverage or purely legal interpretation exists.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.7, 10089.72 and 10089.74, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order, including amendments to subsections (b)(5) and (c), transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Amendment of section and NOTE filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.4. Selection of Mediator; Objections.

(a) Immediately upon referral of a dispute to mediation, the Department shall transfer all information it deems necessary concerning the disputed claim to a mediator of its choosing, provided that such mediator has otherwise met the standards and qualifications set forth in Insurance Code Section 10089.77. Such information shall include, but not be limited to, the name of the insured, the address of the insured, the name of the insurer, and the address of the insurer.

(b) The Department shall select the mediator primarily on a rotation basis. The Department shall select a mediator that has expressed availability to conduct the mediation in the county of the insured's residence. The process of selecting a mediator, and the manner in which the mediator is assigned to mediate a dispute, shall be within the sole discretion of the Department, provided that such mediators have otherwise met the standards and qualifications set forth in Insurance Code Section 10089.77.

(c) After a mediator has been selected by the Department, either party to the mediation may object once to the selection of that mediator. If either party conveys that objection directly to the Department, in writing, the Department shall notify the other party and the mediator, and shall dismiss that mediator and select another mediator within 5 calendar days. If either party conveys an objection to the mediator directly to that mediator, then that mediator shall immediately notify, in writing or otherwise, the Department and the Department shall, within 5 calendar days, dismiss that mediator and select another mediator. Nothing in this subsection shall effect the right of a party to exercise their right to object pursuant to Insurance Code Section 10089.77(b).

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.71, 10089.72, 10089.73 and 10089.74, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order, including amendment of subsection (c), transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Repealer of former section 2696.4 and renumbering of former section 2696.5 to new section 2696.4 filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.5. Mandatory Participation; Appeal.

(a) No insurer may be compelled to participate in mediation except where the Commissioner finds that the insurer has engaged in an arbitrary or unreasonable refusal or refusals to mediate a dispute which the Commissioner has deemed appropriate for mediation. Where the Commissioner so finds, he shall issue upon the insurer an Order to Participate, citing his reasons therein.

(b) Any insurer to whom an Order to Participate has been issued may seek a review of said Order by filing in a court of competent jurisdiction within 30 calendar days of the issuance of that Order. The Commissioner's Order to Participate, however, may not be stayed during the pendency of any judicial proceeding for any period beyond 60 calendar days after the initial date of the Order to Participate. The basis for the Commissioner's decision to require an insurer to participate in the mediation program shall not be made public unless review is sought.

(c) Any insured whose request to mediate his or her claim under this subchapter was declined by an insurer may file a written request to the Commissioner to require the insurer to participate in the mediation program. Upon receipt of such request, the Commissioner shall either:

(1) Issue an Order to Participate pursuant to subsection 2696.5(a); or

(2) Make a written inquiry to the insurer to determine the reasons for declining mediation; or

(3) Issue to the insured a Decision Not to Compel Mediation which sets forth the basis of the Commissioner's decision not to require the insurer to participate in mediation of that dispute.

(d) Any insured to whom a Decision Not to Compel Mediation has been issued, may seek a review of said Decision by filing in a court of competent jurisdiction within 30 calendar days of the issuance of that Decision.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.76 and 10089.77, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Renumbering of former section 2696.5 to section 2696.4 and renumbering of former section 2696.6 to new section 2696.5, including amendment of section, filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.6. Pre-Mediation Procedures; Telephone Conference; Notice of Commencement; Written Statement.

(a) Upon receipt of the Referral to Mediation from the Department, the mediator shall hold a telephone conference prior to the mediation conference to discuss items necessary to the mediation. Necessary items include, but are not limited to:

(1) The date, time, and location of the mediation conference;

(2) Whether the insured will be represented by counsel at the mediation conference and, if so, whether the insurer will be represented by counsel;

(3) What documents will be produced at the mediation conference and whether there is any dispute with respect to the production of documents;

(4) Any other matters as shall promote an effective mediation conference, including attendance and participation of non–parties at the mediation conference.

(b) During the telephone conference, or at any time before the mediation conference commences, the mediator may, in his or her discretion, order either party to produce other documents that the mediator determines to be relevant to the issues under mediation.

(c) Upon completion of the telephone conference, the mediator shall issue a written notice to the insured and the insurer. Such notice shall:

(1) Contain the date, time and location for commencement of the mediation conference;

(2) Advise the parties that the cost of the mediation will be borne by the insurer, except to the extent provided in Insurance Code section 10089.81 and the applicable regulations contained in this subchapter;

(3) State that, in the event of the proposed settlement, the insured may have three business days to rescind the agreement, as specified in subdivision (c) of Insurance Code Section 10089.82.

(d) Within 5 calendar days of the date of the mediation conference, the insurer shall provide the insured and the mediator a written statement of the facts concerning the dispute. Within 5 calendar days before the date of mediation, the insured shall provide the insurer and the mediator a written statement setting forth the allegations and the issues which are the subject of the mediation.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Section 10089.75, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Renumbering of former section 2696.6 to section 2696.5 and renumbering of former section 2696.7 to new section 2696.6, including amendment of section, filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.7. Mediation Conference; Failure to Appear; Confidentiality Agreement.

(a) To the extent possible the mediation conference shall be held within 21 calendar days of the date of transmission of the notice referenced in section 2696.6(c) of this subchapter. If the mediation cannot be commenced within 21 calendar days of this notice, then it shall be commenced as soon as practicable for all parties, as determined by the mediator. To the extent possible, the mediation conference shall be held in the county where the insured resides.

(b) The parties are required to appear for the mediation conference at the date, time, and location set forth on the notice referenced in subsection 2696.6(c). For the purposes of this subchapter, a party has failed to appear at the mediation conference if it:

(1) Fails to be physically present at the conference within 30 (thirty) minutes of the scheduled time;

(2) Fails to send to the conference a representative with full authority to bind settlements.

(c) For the purposes of this subchapter, the following shall apply:

(1) Should either party fail to appear at the mediation conference without good cause, that party shall bear all actual expenses charged by the mediator.

(2) Should both parties fail to appear at the mediation conference without good cause, then all actual expenses charged by the mediator shall be borne equally between the parties.

(d) "Good cause," for the purposes of subsection 2696.7(c), shall include, but not be limited to, the unforeseen circumstances, especially medical emergencies, which preclude the physical presence of a party. The Department, upon review of the facts and circumstances provided by the parties to the mediation, including the mediator, shall decide whether good cause has been demonstrated.

(e) In order to participate in the mediation conference and before the mediation conference commences, each party to the mediation, as well as the mediator, must sign a "Confidentiality Agreement", wherein the parties and the mediator agree that, pursuant to Insurance Code Sections 10089.80(c) and 10089.80(d), as well as California Evidence Code Sections 1115 through and including 1128, the statements made by the parties to the conference, negotiations between the parties, and documents produced at the mediation conference are confidential; and, that the mediator may not file and a court may not consider any declaration or finding of any kind by the mediator, other than a required statement of agreement or nonagreement, unless all parties to the mediation expressly agree otherwise in writing prior to the commencement of the mediation; and that the mediator shall not voluntarily testify on behalf of a party.

(f) Notwithstanding Section 2696.7(e), nothing in this subchapter shall preclude the Department from obtaining the information referenced in Section 2696.8.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.78 and 10089.80, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order, including amendment of subsection (d), transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Renumbering of former section 2696.7 to section 2696.6 and renumbering of former section 2696.9 to new section 2696.7, including amendment of section, filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.8. Post Mediation; Cooling–Off Period; Reporting Requirements.

(a) The insured may be represented at the mediation conference by any person of his or her own choosing. If the parties agree to a settlement agreement, the insured, or their representative, shall have three business days to rescind the agreement. If the agreement is not rescinded by the insured, it is binding on the insured and the insurer, and acts as a release of all specific claims for damages known at the time of the mediation presented and agreed upon in the mediation conference. If counsel for the insured is present at the mediation conference and a settlement is agreed upon that is signed by the insured's counsel, the agreement is immediately binding on the insured and may not be rescinded.

(b) Within 10 calendar days of the conclusion of the mediation, the mediator shall furnish to the department a completed Form CCB–023 B, ([Mediator Report Form] Rev. 11/14/05) incorporated by reference herein.

(c) The completed mediator reports received by the Department pursuant to these regulations shall be used by the Department only for its use in compiling required reports for the legislature and for evaluating the status of the program. The mediator report forms, papers, and any other documents provided by the mediators to the Department in accordance with this subchapter, shall not be subject to subpoena or subpoena duces tecum.

NOTE: Authority cited: Section 10089.83(c), Insurance Code. Reference: Section 10089.80(a), Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).

3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Repealer of former section 2696.8 and renumbering of former section 2696.10 to new section 2696.8, including amendment of section, filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.9. Mediation Conference; Failure to Appear; Confidentiality Agreement.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.78 10089.79, 10089.80 and 10089.81, Insurance Code.

HISTORY

1. New section filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Change without regulatory effect amending subsection (f) filed 5–20–98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 21).
6. Renumbering of former section 2696.9 to section 2696.7 filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

§ 2696.10. Post Mediation; Cooling–Off Period; Reporting Requirements.

NOTE: Authority cited: Section 10089.83, Insurance Code. Reference: Sections 10089.82 and 10089.83, Insurance Code.

HISTORY

1. New section and Form EQM–1 filed 10–15–96; operative 10–15–96 (Register 96, No. 42). A Certificate of Compliance must be transmitted to OAL by 2–12–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 10).
3. New section filed 3–4–97 as an emergency; operative 3–4–97 (Register 97, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–2–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–4–97 order transmitted to OAL 7–3–97 and filed 8–13–97 (Register 97, No. 33).
5. Renumbering of former section 2696.10 to section 2696.8 filed 12–29–2006; operative 1–28–2007 (Register 2006, No. 52).

Subchapter 7.7. California Earthquake Authority

§ 2697. Authority.

These regulations are promulgated pursuant to the authority granted the Insurance Commissioner by the provisions of California Insurance Code Sections 10089.11, and 10089.28(b).

NOTE: Authority cited: Sections 10089.11(a) and 10089.28(b), Insurance Code. Reference: Sections 10089.11(a), 10089.28(b) and 12921, Insurance Code.

HISTORY

1. New subchapter 7.7 (sections 2697–2697.9) and new section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New subchapter 7.7 (sections 2697–2697.9) and new section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New subchapter 7.7 (sections 2697–2697.9) and section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).

§ 2697.1. Purpose.

The purpose of the regulations is to specify procedures for ratemaking and forms approval, define the type and quality of investments the Authority is authorized to make, define coverage types and limits, set forth producer compensation rates, specify the procedures to be followed by the Authority following an earthquake where the magnitude of losses make it likely that prorated benefits may be paid, and instruct participating insurers how and when to notify each of its insureds that the Authority is the provider of earthquake coverage. Promulgation of these regulations, as required by statute, acts to implement, interpret, and make specific Chapter 8.6 (commencing with Section 10089.1) of Part 1 of Division 2 of the California Insurance Code.

NOTE: Authority cited: Sections 10089.11(a) and 10089.28(b), Insurance Code. Reference: Sections 10089.11(a), 10089.28(b) and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).

§ 2697.2. Definitions.

(a) "Authority" means the California Earthquake Authority as created in and authorized by Insurance Code Section 10089.6, subdivision (a).

(b) "Basic residential earthquake insurance policy" means the policy of residential earthquake insurance described in Insurance Code Section 10089, as augmented by the provisions of Insurance Code Section 10089.5, subdivision (c).

(c) "Commissioner" means the Insurance Commissioner of the State of California.

(d) "Board" or "Governing Board" means the Governing Board of the Authority as authorized and required by Insurance Code Section 10089.7, subdivision (a).

(e) "Participating insurer" means an insurer that has elected to join the Authority and, in accordance with all applicable statutory, regulatory, and contractual requirements, has agreed to contribute start–up and contingent capital to the Authority and place all its basic residential earthquake insurance business with the Authority.

(f) "Residential property insurance policy" means those policies described in Insurance Code Section 10087.

(g) A "qualifying residential property" is any residential dwelling described in Insurance Code Section 10087.

NOTE: Authority cited: Sections 10087, 10089, 10089.5(a) and (c), 10089.6(a) and 10089.7(a), Insurance Code. Reference: Sections 10089.11(a) and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).
7. Amendment of section and NOTE filed 5–11–99; operative 6–10–99 (Register 99, No. 20).

§ 2697.3. Ratemaking.

(a) In setting its rates, the Authority shall be governed by the provisions of Insurance Code Section 10089.40.

(b) In order to establish or change any rate, the Authority shall file a complete rate application with the Commissioner. A complete rate application shall include: (1) all the data referred to in Insurance Code Sections 1857.7, provided, however, that the Commissioner may permit the Authority to state that required data in terms that are applicable to and reflective of the Authority's enabling statutes, its status as an instrumentality of the State of California, and its inherent characteristics; (2) the data referred to in Insurance Code Section 1857.9(a); (3) the data required by Insurance Code Section 1864; and (4) such other information as the Commissioner may require.

(c) The Commissioner shall notify the public of any application by the Authority to establish or change any rate. The application shall be deemed approved 60 (sixty) days after that public notice unless (1) a consumer or his or her representative requests a hearing within 45 (forty–five) days of public notice and the Commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or (2) the Commissioner on his or her own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate, in which case the Commissioner must hold a hearing upon a timely request. In any event, a rate change application shall be deemed approved 180 (one–hundred eighty) days after the rate application is received by the Commissioner (A) unless that application has been disapproved by a final order of the Commissioner subsequent to a hearing, or (B) extraordinary circumstances exist. For purposes of this section, "received" means the date received by the Department's Rate Filing Bureau in San Francisco.

(d) For purposes of subdivision (c), extraordinary circumstances include the following:

(1) Rate change application hearings commenced during the 180–day period provided by subdivision (c). If a hearing is commenced during the 180–day period, the rate change application shall be deemed approved upon expiration of the 180–day period or 60 days after the close of the record of the hearing, whichever is later, unless disapproved prior to that date.

(2) Rate change applications that are not approved or disapproved within the 180–day period provided by subdivision (c) as a result of a judicial proceeding directly involving the application and initiated by the applicant or an intervenor. During the pendency of the judicial proceedings, the 180–day period is tolled, except that in no event shall the Commissioner have less than 30 days after conclusion of the judicial proceedings to approve or disapprove the application. Notwithstanding any other provision of law, nothing shall preclude the Commissioner from disapproving an application without a hearing if a stay is in effect barring the Commissioner from holding a hearing within the 180–day period.

(3) The hearing has been continued pursuant to Section 11524 of the Government Code. The 180–day period provided by subdivision (c) shall be tolled during any period in which a hearing is continued pursuant to Section 11524 of the Government Code. A continuance pursuant to Section 11524 of the Government Code shall be decided on a case–by–case basis. If the hearing is commenced or continued during the 180–day period, the rate change application shall be deemed approved upon the expiration of the 180–day period or 100 days after the record is closed, whichever is later, unless disapproved prior to that date.

(e) Public notice required by this Section shall be made as required by Insurance Code Section 1861.06.

(f) With the exception of proprietary materials and documents owned or licensed by third parties, all information the Authority provides to the Commissioner pursuant to this Section shall be available for public inspection, and the provisions of Section 6254(d) of the Government Code and Section 1857.9 of the Insurance Code shall not apply to that information.

(g) Hearings shall be conducted pursuant to Sections 11500 through 11528 of the Government Code, except that: (1) hearings shall be conducted by administrative law judges for purposes of Sections 11512 and 11517, chosen under Section 11502 or appointed by the Commissioner; (2) hearings are commenced by a filing of a Notice in lieu of Sections 11503 and 11504; (3) the Commissioner shall adopt, amend or reject a decision only under Section 11517(c) and (e) and solely on the basis of the record; (4) Section 11513.5 shall apply to the Commissioner; (5) discovery shall be liberally construed and disputes determined by the administrative law judge.

(h) Judicial review shall be in accordance with Insurance Code Section 1858.6. For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

(i) The rights provided by Insurance Code Section 1861.10 shall apply to all proceedings pursuant to which the Authority acts to establish its rates for earthquake insurance.

(j) If at any time the Authority for any reason has no valid rates in effect, or has rates in effect that are shown to be excessive, inadequate, or unfairly discriminatory, the Insurance Commissioner may approve, based on a complete rate application filed by the Authority, interim rates for Authority policies of residential earthquake insurance, and those interim rates shall remain in effect until the Commissioner approves an Authority rate that complies with the provisions of this Section.

NOTE: Authority cited: Sections 1861.05, 1861.06, 1861.10, 10089.11(d), 10089.40 and 12921, Insurance Code; and *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d 805, 771 P.2d 1247, 258 Cal. Rptr. 161. Reference: Sections 1857.7, 1857.9, 1864, 10089.11(a) and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).
7. Amendment of subsections (d)(3) and (f) filed 10–16–2002; operative 11–15–2002 (Register 2002, No. 42).

§ 2697.4. Forms Approval and Filing.

(a) The Authority shall draft policies of earthquake insurance that are consistent with its enabling statutes and Plan of Operation. Before the Authority issues any policy of earthquake insurance, the policy shall first be considered and specifically approved by the Governing Board.

(b) After the Governing Board's approval, the Authority shall file the approved policies with the Department of Insurance and shall not offer any policy for sale until the Insurance Commissioner has approved its form and content.

NOTE: Authority cited: Sections 10089.11 and 10089.28, Insurance Code. Reference: Sections 10089.11(a) and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).

5. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).

§ 2697.5. Investments.

(a) The investments of the Authority shall be limited to those securities eligible under Section 16430 of the Government Code.

(b) The California Earthquake Authority shall invest moneys that are deposited in the California Earthquake Authority Fund according to the investment policies and guidelines adopted from time to time by the Board. Moneys of the Authority may be invested and deposited according to the provisions of Insurance Code Section 10089.22(c).

NOTE: Authority cited: Sections 10089.6 and 10089.22(c), Insurance Code; and Section 16430, Government Code. Reference: Sections 10089.7, 10089.11 and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).

§ 2697.6. Earthquake Policies, Coverage Types and Limits.

(a) The Authority must offer, in accordance with the provisions of Division 2, Part 1, Chapter 8.5, of the Insurance Code, a basic residential earthquake insurance policy to any owner of a qualifying residential property, as long as the qualifying residential property meets the eligibility standards of the Authority and the owner has first secured a residential property insurance policy from a participating insurer.

(b) The Authority must renew any basic residential earthquake insurance policy it has written, provided that the Authority receives payment of the applicable renewal premium on or before the expiration date stated in the policy. The Authority must nonrenew, rescind, or cancel a policy on any otherwise qualified residential property whenever the property is no longer covered by an underlying residential property insurance policy issued by a participating insurer.

(c) No policy issued by the Authority will provide coverage in the event there is no underlying residential property insurance policy issued by a Participating Insurer at the time of loss. In that case, any unearned premium shall be returned to the policyholder on a pro rata basis.

(d) The types of policies, base–limits policy coverage limits, and base–limits policy deductibles of Authority policies shall be as follows:

1. Dwelling policy:

Coverage A (Dwelling)	Limit of insurance equal to the stated Coverage A limit (however the limit on liability for the structure may be denominated in the residential property insurance policy, without adjustment of the stated dollar amount for inflation or similar modification) of underlying residential property insurance policy; maximum deductible 15% of Coverage A limit
Coverage B	Limited coverage, included in Coverage A limit and subject to Coverage A deductible
Coverage C (Personal Property/Contents)	No less than $5,000 limit of insurance; no payment unless structural loss meets Coverage A deductible
Coverage D (Loss of Use)	No less than $1,500 limit of insurance; no deductible
Limited Building Code Upgrade	No less than $10,000 limit of insurance, subject to Coverage A deductible

2. Individual condominium or cooperative unit policy:

Coverage A (Real Property)	No less than $25,000 limited of insurance; maximum deductible 15% of Coverage A limit; plus no less than $10,000 Limited Building Code Upgrade coverage as additional insurance, subject to Coverage A deductible
Coverage C (Personal Property/Contents)	No less than $5,000 limit of insurance; maximum deductible 15% of Coverage C limit
Coverage D (Loss of Use)	No less than $1,500 limit of coverage; no deductible
Coverage E (Loss Assessment)	For condominium units valued at $135,000 or more, no less than $50,000 limit of coverage; for condominium units valued at less than $135,000, no less than $25,000 limit of coverage; maximum deductible 15% of Coverage E limit

3. Renter's policy:

Coverage C (Personal Property)	No less than $5,000 limit of insurance; maximum deductible 15% of Coverage C limit
Coverage D (Loss of Use)	No less than $1,500 limit of insurance; no deductible

(e) The Authority may issue basic residential earthquake insurance policies with limits of insurance greater than the required minimum limits of insurance set forth in subdivision (d) or with lower deductibles than the maximum deductibles set forth in subdivision (d), referred to in this Chapter as "optional limits basic residential earthquake insurance." In issuing its optional–limits basic residential earthquake insurance policies, the Authority must provide full financial backing in accordance with a written plan of finance. The plan of finance may include the purchase by the Authority of reinsurance and financial guaranty insurance on terms

and at the limits that the Authority may find reasonable and appropriate, to secure the payment of claims obligations and expenses that may arise under its optional–limits basic residential earthquake insurance policies.

(f) With respect to individual condominium unit policies, the value of the land on which a condominium unit is constructed is to be excluded when determining the value of that condominium unit for the purpose of determining the minimum limit of insurance for Coverage E (Loss Assessment).

NOTE: Authority cited: Sections 10087, 10089.5(c), 10089.11, 10089.20 and 10089.26(a)(1), Insurance Code. Reference: Sections 10089, 10089.11(a), 10089.28(b) and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).
7. Amendment of section and NOTE filed 5–11–99; operative 6–10–99 (Register 99, No. 20).
8. Amendment of subsections (d) and (e) filed 3–9–2006 as an emergency; operative 3–9–2006 (Register 2006, No. 10). A Certificate of Compliance must be transmitted to OAL by 7–7–2006 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 3–9–2006 order transmitted to OAL 6–13–2006 and filed 7–12–2006 (Register 2006, No. 28).
10. Amendment of subsection (e) filed 11–15–2006 as an emergency; operative 11–15–2006 (Register 2006, No. 46). A Certificate of Compliance must be transmitted to OAL by 3–15–2007 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 11–15–2006 order, including further amendment of subsection (e), transmitted to OAL 3–15–2007 and filed 4–25–2007 (Register 2007, No. 17).
12. Amendment filed 4–30–2008; operative 5–30–2008 (Register 2008, No. 18).

§ 2697.61. Additional Requirements for Offer of Optional–Limits Basic Residential Earthquake Insurance Policies.

(a) Before the Authority may offer optional–limits basic residential earthquake insurance policies, the governing board must first certify that selling such insurance furthers the Authority's charge in Insurance Code Section 10089.10 to achieve maximum capacity for writing earthquake coverage. The sale by the Authority of any optional–limits basic residential earthquake insurance policies must be actuarially sound.

(b) The Commissioner finds that integrating the formerly separate optional–limits program that had been in operation from 1999 through 2007 with the base–limits program serves the public interest by permitting the two programs to be financed together at an expected overall saving and by simplifying the program for the Authority, participating insurers, and consumers. This integration renders the former maintenance of separate funds within the Authority unnecessary and inappropriate. Any inter–fund transfer obligation that may exist at the time of integration will cease to exist.

NOTE: Authority cited: Sections 10087, 10089.5(c), 10089.11, 10089.20 and 10089.26(a)(1), Insurance Code. Reference: Sections 10089, 10089.11(a), 10089.28(b) and 12921, Insurance Code.

HISTORY

1. New section filed 5–11–99; operative 6–10–99 (Register 99, No. 20).
2. New subsections (b)(iii)–(v) filed 11–15–2006 as an emergency; operative 11–15–2006 (Register 2006, No. 46). A Certificate of Compliance must be transmitted to OAL by 3–15–2007 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 11–15–2006 order, including further amendment of subsection (b), redesignation and amendment of former subsection (b)(iii), (b)(iv) and (b)(v) as new subsections (c), (c)(i) and (c)(ii) and subsection relettering, transmitted to OAL 3–15–2007 and filed 4–25–2007 (Register 2007, No. 17).
4. Amendment of subsection (a), repealer of former subsections (b)–(e) and new subsection (b) filed 4–30–2008; operative 5–30–2008 (Register 2008, No. 18).

§ 2697.7. Producer Compensation.

(a) The rate of commission payable by the Authority as producer compensation shall be 10% (ten percent) of the gross written premium for the policy.

(b) In the event of cancellation of a basic residential earthquake insurance policy issued by the Authority, or the issuance by the Authority of an endorsement that requires a premium to be returned to the insured, the producer shall refund to the insured or the Authority, as applicable and on a pro rata basis, commissions on the unearned premium.

NOTE: Authority cited: Section 10089.11(b), Insurance Code. Reference: Sections 10089.11 and 12921, Insurance Code.

HISTORY

1. New section filed 11–18–96 as an emergency; operative 11–18–96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3–18–97 or emergency language will be repealed by operation of law on the following day.
2. Amendment of subsection (a) filed 12–19–96 as an emergency; operative 12–19–96 (Register 96, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–18–97 or emergency language will be repealed by operation of law on the following day.
3. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
4. New section filed 4–1–97 as an emergency; operative 4–1–97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7–30–97 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
6. New section filed 8–4–97 as an emergency; operative 8–4–97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–2–97 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 8–4–97 order transmitted to OAL 11–26–97 and filed 1–13–98 (Register 98, No. 3).

§ 2697.8. Payment Plan Following Losses that Exceed the Authority's Available Assets.

(a) Upon the occurrence of any earthquake event in the State that is likely to give rise to significant covered losses, the staff of the Authority shall, within seven (7) calendar days of the date of the earthquake event, cause to be created a scientific model of anticipated, covered losses from that event. The output of the model for that event, as interpreted by Authority staff and retained actuary, shall be presented forthwith to the Board, which shall within 72 (seventy–two) hours of receipt of that output convene as a group in a formal meeting, either in person or by teleconference, to consider the information presented. At the outset of the Board meeting contemplated by this Section, the Board shall hold a vote to make a finding that the meeting about to occur as a result of an "emergency situation," within the meaning of Government Code Section 11125.5, subdivisions (a) and (b). In the absence of a finding of an "emergency situation" for that meeting, the Board shall adjourn forthwith and reconvene after providing public notice of that reconvened meeting in accordance with Government Code Section 11125, subdivision (a).

(b) In the event the Board in its sole discretion determines that anticipated covered losses following an earthquake may exhaust the Authority's capital and that no additional source of funds such as available insurer assessments, proceeds of reinsurance contracts, proceeds of capital markets contracts, and all other funds available to or due the Authority, will be available to the Authority to pay policyholder claims, the Board shall draw up and present to the Insurance Commissioner a plan to pay covered earthquake claims against the Authority on a pro rata or installment basis.

(c) The payment plan shall ensure the equitable distribution of available CEA assets to all policyholders who have covered earthquake claims against the Authority. Upon approval of the plan by the Commissioner, the Board shall implement the plan. The plan shall be updated and resubmitted to the Commissioner for his or her approval at the end of every succeeding 30–day period until all outstanding CEA claims have been closed or otherwise discharged.

(d) The plan shall ensure the maintenance of sufficient capital to ensure the continued operation of the Authority for the purpose of paying claims; discharging Authority debts, including bonded indebtedness; and paying or providing for other obligations of the Authority.

(e) The Authority's Plan of Operation shall be consistent with the provisions of this Section.

NOTE: Authority cited: Section 10089.11(b) and 10089.35(a), Insurance Code. Reference: Sections 10089.11 and 12921, Insurance Code.

HISTORY

1. New section filed 11-18-96 as an emergency; operative 11-18-96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3-18-97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4-1-97 as an emergency; operative 4-1-97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7-30-97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8-4-97 as an emergency; operative 8-4-97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12-2-97 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8-4-97 order transmitted to OAL 11-26-97 and filed 1-13-98 (Register 98, No. 3).

§ 2697.9. Notice Requirements.

(a) All participating insurers shall comply with the notice requirements imposed by subdivision (a) of Section 10083 of the Insurance Code.

(b) Upon the acceptance by an insured of an offer of earthquake insurance and issuance of a policy of basic residential earthquake insurance by the Authority, the participating insurer shall provide the following notice to the policyholder in at least 14-point, boldface type on the declarations page of the policy or on the policy jacket:

CALIFORNIA EARTHQUAKE AUTHORITY POLICY DISCLOSURE

THIS POLICY IS BEING PURCHASED FROM THE CALIFORNIA EARTHQUAKE AUTHORITY ("CEA"). THE COVERAGE IN THIS CEA POLICY SUBSTANTIALLY DIFFERS FROM THE COVERAGES PROVIDED IN YOUR HOMEOWNER'S POLICY. THE CEA IS NOT PART OF OR ASSOCIATED WITH YOUR HOMEOWNER'S INSURANCE COMPANY. IF LOSSES AS A RESULT OF AN EARTHQUAKE OR A SERIES OF EARTHQUAKES EXCEED THE AVAILABLE RESOURCES OF THE CEA, THIS POLICY IS NOT COVERED BY THE CALIFORNIA INSURANCE GUARANTY ASSOCIATION. THEREFORE, THE CALIFORNIA INSURANCE GUARANTY ASSOCIATION WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE CEA BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED. IN ADDITION, YOUR CEA POLICY MAY BE SUBJECT TO FUTURE SURCHARGES OF THE POLICY PREMIUM IN CERTAIN CASES WHERE AN EARTHQUAKE OR SERIES OF EARTHQUAKES HAS EXCEEDED AVAILABLE RESOURCES TO PAY CLAIMS. IN THAT CASE, THIS MEANS THAT IN ADDITION TO THE ANNUAL PREMIUM, YOU MAY BE CHARGED UP TO AN ADDITIONAL 20% OF THE PREMIUM.

(c) The Authority and each participating insurer shall comply with the requirements imposed by Insurance Code Section 10086(a)(3) for all policies of basic residential earthquake insurance issued by the Authority.

(d) If a policy issued by the Authority includes a premium surcharge, the participating insurer shall provide the insured a notice in a stand-alone document which states that the policyholder may cancel or nonrenew the basic residential earthquake policy. The participating insurer shall provide the statement with the premium billing. The notice shall include the following statement in 14-point, boldface type:

NOTICE OF SURCHARGE ON CEA EARTHQUAKE INSURANCE POLICY AND RIGHT TO CANCEL

A SURCHARGE HAS BEEN INCLUDED IN THE PREMIUM FOR YOUR CEA EARTHQUAKE INSURANCE POLICY. YOU MAY CHOOSE TO RENEW THIS POLICY AT THE NEW RATE OR YOU MAY CANCEL OR NONRENEW YOUR CEA EARTHQUAKE INSURANCE POLICY. CANCELLATION OR NONRENEWAL OF YOUR CEA POLICY WILL HAVE NO EFFECT ON YOUR HOMEOWNER'S OR FIRE INSURANCE POLICY. HOWEVER, IF YOU WANT EARTHQUAKE INSURANCE TO BE PROVIDED BY THE CEA, YOU MUST PAY THE FULL PREMIUM FOR THE CEA POLICY, INCLUDING THE SURCHARGE.

The participating insurer may add explanatory language approved by the Commissioner to augment and explain the mandatory notice language in this paragraph (d).

NOTE: Authority cited: Sections 10086(a)(3), 10089.11, 10089.28(b) and 10089.29(b)(2), Insurance Code. Reference: Sections 10089.6, 10089.11, 10089.28 and 12921, Insurance Code.

HISTORY

1. New section filed 11-18-96 as an emergency; operative 11-18-96 (Register 96, No. 47). A Certificate of Compliance must be transmitted to OAL by 3-18-97 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 14).
3. New section filed 4-1-97 as an emergency; operative 4-1-97 (Register 97, No. 14). A Certificate of Compliance must be transmitted to OAL by 7-30-97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 32).
5. New section filed 8-4-97 as an emergency; operative 8-4-97 (Register 97, No. 32). A Certificate of Compliance must be transmitted to OAL by 12-2-97 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of NOTE (Register 98, No. 3).
7. Certificate of Compliance as to 8-4-97 order transmitted to OAL 11-26-97 and filed 1-13-98 (Register 98, No. 3).

Subchapter 8. California Residential Earthquake Recovery Fund

Article 1. Definitions

§ 2698. Definitions.

NOTE: Authority cited: Sections 5001.5, 5003(g) and 5010, Insurance Code. Reference: Sections 5000, 5001, 5001.5, 5003(a), 5003(b), 5003(g), 5004, 5005(a), 5005(c), 5008 and 5010, Insurance Code.

HISTORY

1. Repealer of subchapter 8 (sections 2692-2692.2) by operation of law. For prior history, see Register 91, No. 40. New subchapter 8 (sections 2698-2698.21) filed 9-16-91 as an emergency; operative 9-16-91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1-14-92 or emergency language will be repealed by operation of law on the following day.
2. New section filed 2-26-92 as an emergency; operative 2-26-92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6-25-92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2-26-92 order transmitted to OAL 3-19-92 and filed 4-22-92 (Register 92, No. 23).
4. Change without regulatory effect repealing subchapter 8, article 1 and section filed 5-1-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 2. Collections

§ 2698.1. Determination to Collect.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Sections 5001(c), 5003(c) and 5008, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 2 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.2. Collection Procedures.

NOTE: Authority cited: Sections 5003(a), 5003(g), 5005(c) and 5010, Insurance Code. Reference: Sections 5003 and 5005(c), Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.3. Administrative Fees.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5003(b), Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 3. Remittance of Surcharge and Information

§ 2698.4. Remittance of Surcharge.

NOTE: Authority cited: Sections 5003(a) and 5010, Insurance Code. Reference: Sections 5003(a) and 5003(c), Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 3 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.5. Remittance of Information.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5003(c), Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 4. Duties and Liability for Surcharge

§ 2698.6. Duties.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5003, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 4 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.7. Liability for Surcharge.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5003, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 5. Claims and Appeals

§ 2698.8. Filing Claims and Late Appeals.

NOTE: Authority cited: Assembly Bill No. 2049, Chapter 1251. Reference: An act to repeal Chapter 4.5 (Commencing with Section 5000) of Part 1 of division 2 of the Insurance Code, relating to insurance and making an appropriation therfor.

[The next page is 752.7.]

(Approved by Governor September 29, 1992. Filed with Secretary of State September 30, 1992.)

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction amending Register number in HISTORY 1 (Register 92, No. 19).
4. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
5. Amendment of article heading, section heading, text and repealer and new NOTE filed 4–13–94 as an emergency; operative 4–13–94 (Register 94, No. 15). A Certificate of Compliance must be transmitted to OAL by 8–11–94 or emergency language will be repealed by operation of law on the following day.
6. Change without regulatory effect repealing article 5 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.9. Claims Adjustment.

NOTE: Authority cited: Assembly Bill No. 2049, Chapter 1251. Reference: An act to repeal Chapter 4.5 (Commencing with Section 5000) of Part 1 of division 2 of the Insurance Code, relating to insurance and making an appropriation therfor. (Approved by Governor September 29, 1992. Filed with Secretary of State September 30, 1992.)

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction amending Register number in HISTORY 1 (Register 92, No. 19).
4. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
5. Amendment of section and repealer and new NOTE filed 4–13–94 as an emergency; operative 4–13–94 (Register 94, No. 15). A Certificate of Compliance must be transmitted to OAL by 8–11–94 or emergency language will be repealed by operation of law on the following day.
6. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.10. Eligibility Appeal.

NOTE: Authority cited: Assembly Bill No. 2049, Chapter 1251. Reference: An act to repeal Chapter 4.5 (Commencing with Section 5000) of Part 1 of division 2 of the Insurance Code, relating to insurance and making an appropriation therfor. (Approved by Governor September 29, 1992. Filed with Secretary of State September 30, 1992.)

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction amending Register number in HISTORY 1 (Register 92, No. 19).
4. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
5. Amendment of section and repealer and new NOTE filed 4–13–94 as an emergency; operative 4–13–94 (Register 94, No. 15). A Certificate of Compliance must be transmitted to OAL by 8–11–94 or emergency language will be repealed by operation of law on the following day.
6. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.11. Payment Appeal.

NOTE: Authority cited: Assembly Bill No. 2049, Chapter 1251. Reference: An act to repeal Chapter 4.5 (Commencing with Section 5000) of Part 1 of division 2 of the Insurance Code, relating to insurance and making an appropriation therfor. (Approved by Governor September 29, 1992. Filed with Secretary of State September 30, 1992.)

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Amendment of section and repealer and new NOTE filed 4–13–94 as an emergency; operative 4–13–94 (Register 94, No. 15). A Certificate of Compliance must be transmitted to OAL by 8–11–94 or emergency language will be repealed by operation of law on the following day.
5. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.12. Determination of Appeal.

NOTE: Authority cited: Assembly Bill No. 2049, Chapter 1251. Reference: An act to repeal Chapter 4.5 (Commencing with Section 5000) of Part 1 of division 2 of the Insurance Code, relating to insurance and making an appropriation therfor. (Approved by Governor September 29, 1992. Filed with Secretary of State September 30, 1992.)

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Amendment of section heading and text and repealer and new NOTE filed 4–13–94 as an emergency; operative 4–13–94 (Register 94, No. 15). A Certificate of Compliance must be transmitted to OAL by 8–11–94 or emergency language will be repealed by operation of law on the following day.
5. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 6. Payments

§ 2698.13. Distributions.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5005, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 6 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.14. Limitations.

NOTE: Authority cited: Sections 5003(g) and 5010, Insurance Code. Reference: Sections 5003(g), 5005, 5005.1, 5005.2 and 5007, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 7. Records, Accounting, Inspections and Audits

§ 2698.15. Records.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Sections 5002, 5003 and 1727, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 7 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.16. Accounting.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Sections 5002 and 5003, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.17. Inspections and Audits.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Sections 5002 and 5003, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 8. Notices

§ 2698.18. Notices.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5009, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 8 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 9. Confidentiality

§ 2698.19. Information Confidential.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5002, Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 9 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

§ 2698.20. Disclosure.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Section 5003, Insurance Code; and section 1798.24, Civil Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Article 10. Enforcement

§ 2698.21. Failures to Pay, Collect or Remit.

NOTE: Authority cited: Section 5010, Insurance Code. Reference: Sections 5003 and 5005(c), Insurance Code.

HISTORY

1. New section filed 9–16–91 as an emergency; operative 9–16–91 (Register 92, No. 12). A Certificate of Compliance must be transmitted to OAL 1–14–92 emergency language will be repealed by operation of law on the following day.
2. New section filed 2–26–92 as an emergency; operative 2–26–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 6–25–92 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 2–26–92 order transmitted to OAL 3–19–92 and filed 4–22–92 (Register 92, No. 23).
4. Change without regulatory effect repealing article 10 and section filed 5–1–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).

Subchapter 9. Insurance Fraud

Article 2. Special Investigative Unit Regulations

§ 2698.30. Definitions.

As used in this article, the following definitions shall apply:

(a) "Act" means any violation of California Code of Regulations, Title 10, Chapter 5, Section 2698.30–42, inclusive.

(b) "Authorized governmental agency (agencies)" shall have the same meaning as used in the Insurance Frauds Prevention Act (IFPA).

(c) "Claims handler" means every employee and agent of an insurer whose principal responsibilities include the investigation, adjustment, settlement and resolution of claims.

(d) "Commissioner" means the Insurance Commissioner of the State of California.

(e) "Communication" includes the referral of suspected insurance fraud to the Department of Insurance and providing information and documents requested by the Fraud Division.

(f) "Department" means the California Department of Insurance.

(g) "Fraud Division" means the California Department of Insurance Fraud Division formerly known as the Bureau of Fraudulent Claims.

(h) "Hearing" means an adjudicative proceeding initiated by the Insurance Commissioner pursuant to the provisions of California Insurance Code Section 1875.24(d).

(i) "Inadvertent" means unintentional.

(j) "Insurer" means every insurer admitted to do business in this state except the following:

(1) Reinsurers.

(2) Title insurers.

(3) Fraternal fire insurers.

(4) Fraternal benefit societies.

(5) Firemen, policemen, or peace officer benefit and relief associations.

(6) Grant and annuity societies.

(7) Home protection.

(k) "Integral anti–fraud personnel" includes insurer personnel who the insurer has not identified as being directly assigned to its SIU but whose duties may include the processing, investigating, or litigation pertaining to payment or denial of a claim or application for adjudication or claim or application for insurance. These personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties.

(*l*) "Reasonable belief" is a level of belief that an act of insurance fraud may have or might be occurring for which there is an objective justification based on articulable fact(s) and rational inferences therefrom.

(m) "Red flag" or "red flag event" means facts, circumstances or events which, singly or in combination, support(s) an inference that insurance fraud may have been committed.

(n) "Regulations" means these regulations, California Code of Regulations, Title 10, Chapter 5, Subchapter 9, Article 2.

(o) "Special Investigative Unit" (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be comprised of insurer employees or by contracting with other entities for the purpose of complying with applicable sections of the Insurance Frauds Prevention Act (IFPA) for the direct responsibility of performing the functions and activities as set forth in these regulations.

(p) "Suspected insurance fraud" includes any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanations of benefits (EOB), medical evaluations or billings, medical provider notes (commonly known as SOAPE notes); Subjective complaint, Objective findings, Assessment, Plan and Evaluation, Health Care Financing Administration (HCFA) forms, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

(q) "The Insurance Frauds Prevention Act" or "(IFPA)" shall refer to California Insurance Code section 1871–1879.8.

(r) "Willful" means a purpose or willingness to commit the act or make the omission referred to in the California Insurance Code or in these regulations. The Commissioner shall use the factors set forth at California Code of Regulations Section 2591.3(d)(1)(A–E) to determine whether or not an act is willful.

NOTE: Authority cited: Sections 1872.4, 1875.24, 1877.3, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 9080, 10970, 11400, 11520, 11760, 11880, 12400.1, 12743, 12921(a) and 12926, Insurance Code.

HISTORY

1. Repealer of article 2 (sections 2698.40–2698.45), new article 2 (sections 2698.30–2698.42) and new section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. Repealer of of article 2 (sections 2698.40–2698.45), new article 2 (sections 2698.30–2698.42) and new section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. Repealer of of article 2 (sections 2698.40–2698.45), new article 2 (sections 2698.30–2698.42) and new section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. Repealer of of article 2 (sections 2698.40–2698.45), new article 2 (sections 2698.30–2698.42) and new section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. Repealer of article 2 (sections 2698.40–2698.45), new article 2 (sections 2698.30–2698.42) and new section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. Repealer of article 2 (sections 2698.40–2698.45), new article 2 (sections 2698.30–2698.42) and new section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.31. Insurer Responsibility.

The insurer shall comply with applicable sections of the IFPA and these regulations regarding the establishment, operation and continuous existence of an SIU.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.32. SIU Staffing.

(a) Adequacy. The adequacy of an insurer's SIU staffing shall be determined by its demonstrated ability to establish, operate and maintain an SIU that is in compliance with these regulations. Factors that may be considered in staffing the SIU include, but not limited to, the number of policies written and individuals insured in California, number of claims received with respect to California insureds on an annual basis, volume of suspected fraudulent California claims currently being detected and other factors relating to the vulnerability of the insurer to insurance fraud.

(b) Knowledge. An SIU shall be composed of employees who have knowledge and/or experience in general claims practices, the analysis of claims for patterns of fraud, and current trends in insurance fraud, education and training in specific red flags, red flag events, and other criteria indicating possible fraud. They shall have the ability to conduct effective investigations of suspected insurance fraud and be familiar with insurance and related law and the use of available insurer related database resources.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161,

771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.33. SIU Contracted Responsibilities.

(a) Any contract entered into by an insurer, or an entity under contract with an insurer as provided under these regulations, shall not relieve the insurer of any obligation under these regulations or the IFPA.

(b) Notwithstanding any other provisions of these regulations, a complete and executed copy of any such agreement, including all attachments, exhibits and amendments thereto, shall be provided to the Fraud Division on execution.

(c) Any contract entered into by an insurer under this section shall:

(1) Specify all SIU duties and functions to be performed by the parties to the contract and how the insurer monitors performance of the contract responsibilities;

(2) Not include provisions that could provide disincentives to the referral and/or investigation of suspected insurance fraud;

(3) Not include provisions that purport to relieve an insurer of any obligation to comply with the requirements of these regulations and the IFPA.; and

(4) Expressly include a provision to require the contracted entity to comply with all applicable provisions of the IFPA and these regulations.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24,1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.34. Communication with the Fraud Division and Authorized Governmental Agencies.

(a) The insurer and any entity performing the SIU function(s) shall comply with specific sections of the IFPA regarding communication with the Fraud Division and authorized governmental agencies.

(b) On written request by the Fraud Division or an authorized governmental agency, an insurer or its agents, shall release in a timely and complete manner any or all relevant information deemed important that the insurer may possess relating to any specific incident of insurance fraud. Such information shall include:

(1) Insurance policy information;

(2) Applications;

(3) Policy premium payment records;

(4) History of claims;

(5) Information relating to the carrier's investigation, including statements, proof and notice of loss;

(6) Claim file documents;

(7) Claim notes;

(8) Investigation files;

(9) Investigator notes; and

(10) Other information which the Fraud Division or an Authorized Governmental Agency may deem relevant and important.

(c) For the purpose of this section, timely release of information means immediate, but no more than thirty (30) calendar days after the request unless otherwise agreed to by the Fraud Division.

(c) A single written request shall be considered sufficient to compel production of all information deemed relevant by the requesting governmental agency relating to any specific insurance fraud investigation. The single request is applicable throughout the duration of the investigation and is applicable to the requested records of the insurer named in the request and the records of all persons, agents and brokers employed by and conducting business on behalf of the insurer.

NOTE: Authority cited: Sections 1872.4, 1875.24, 1877.3, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1872.3, 1873, 1874.2, 1874.4, 1875.4, 1875.20, 1875.21, 1875.24, 1877.1, 1877.2, 1877.3, 1877.4, 1877.5, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by

8–29–2005 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.35. Detecting Suspected Insurance Fraud.

(a) An insurer's integral anti–fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti–fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against:

(1) Patterns or trends of possible fraud;

(2) Red flags;

(3) Events or circumstances present on a claim;

(4) Behavior or history of person(s) submitting a claim or application; and

(5) Other criteria that may indicate possible fraud.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.36. Investigating Suspected Insurance Fraud.

(a) The SIU shall establish, maintain, distribute and adhere to written procedures for the investigation of possible suspected insurance fraud. An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction.

(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.

(3) Utilizing industry–recognized databases.

(4) Preservation of documents and other evidence.

(5) Writing a concise and complete summary of the investigation, including the investigator's findings regarding the suspected insurance–fraud and the basis for their findings.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.37. Referral of Suspected Insurance Fraud.

(a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and, as required, district attorneys.

(b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

(c) Referrals shall be made within the period specified by statute.

(d) The requirements of this section do not affect the immunity granted under California Insurance Code section 1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act.

(e) The requirements of this section do not diminish statutory requirements contained in the Insurance Frauds Prevention Act regarding the confidentiality of any information provided in connection with an investigation.

NOTE: Authority cited: Section 1708, Civil Code; Sections 1872.4, 1874.6, 1875.24, 1875.4, 1877.3, 1877.5, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1872.5, 1873.2, 1874.2, 1874.4, 1875.20, 1875.21, 1875.24, 1877.3, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by

8–29–2005 or emergency language will be repealed by operation of law on the following day.

8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.38. Referral Content.

A referral of an act of suspected insurance fraud to the Fraud Division shall be legible and on a form as directed by the Department and contain the information and data to the extent applicable, as provided in the following:

(a) Fraud and referral type

(1) Fraud type

(2) New referral/amended referral indicator

(b) Reporting party information

(1) Reporting party type

(2) Reporting party name

(3) Reporting party California Company number

(4) Reporting self–insured/contracted third party license number, as appropriate

(5) Reporting party address, city, state and zip code

(6) Reporting party email address (generally, contact address)

(c) Alleged victim information, as appropriate

(1) Alleged victim company name

(2) Alleged victim California Company number

(3) Alleged victim self–insured number

(4) Alleged victim address, city, state and zip code

(d) Insurance policy or claim information, as appropriate

(1) Claim number associated with referral

(2) Insurance policy number associated with referral

(3) Date of loss or injury

(4) Geographic location where loss or injury occurred

(5) Insurance premium dollar loss

(6) Total potential loss on claim prior to the identification of fraud

(7) Total claim loss paid to date

(8) Actual suspected fraudulent loss amount paid to date

(9) A complete synopsis of all the facts on which the reasonable belief of the insurance fraud is based.

(10) Disaster claim indicator

(e) Other agency referral information, as appropriate

(1) Names of other authorized governmental agencies receiving this referral

(2) Names of any District Attorney's Office receiving this referral

(3) National Insurance Crime Bureau (NICB) referral indicator

(4) The names of any other agencies receiving this referral

(f) Referral contact information, as appropriate

(1) Referral contact name and phone number

(2) Claim or case file handler and phone number

(3) Name and phone number of person who completed referral

(4) Date referral was completed

(g) Information for each party associated with the referral

(1) Identification of the role of the party to the loss

(2) Phone number

(3) Address, city, state and zip code

(4) Date of birth or age

(5) Social security number

(6) Tax identification number

(7) Drivers license number

(8) State of party's drivers license

(9) Vehicle license plate number

(10) Vehicle license plate state

(11) Vehicle identification number

(12) Other names or identifiers used by the party

(13) Claim of injury indicator

NOTE: Authority cited: Sections 1872.4, 1874.2, 1875.24, 1877.3, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1877.3, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.39. Anti–Fraud Training.

Requirements for training provided by and for the SIU shall include:

(a) The insurer shall establish and maintain an ongoing anti–fraud training program, planned and conducted to develop and improve the anti–fraud awareness skills of the integral anti–fraud personnel

(b) The insurer shall designate an SIU staff person to be responsible for coordinating the ongoing anti–fraud training program.

(c) The anti–fraud training program shall consist of three (3) levels:

(1) All newly–hired employees shall receive an anti–fraud orientation within ninety (90) days of commencing assigned duties. The orientation shall provide information regarding:

(A) the function and purpose of the SIU;

(B) an overview of fraud detection and referral of suspected insurance fraud to the SIU for investigation;

(C) a review of Fraud Division insurance fraud reporting requirements:

(D) an organization chart depicting the insurer's SIU; and

(E) SIU contact telephone numbers.

(2) Integral anti–fraud personnel shall receive annual anti–fraud in–service training, which shall include:

(A) review of the function and purpose of the SIU;

(B) introduction/review of the written procedures established by the SIU regarding the identification, documentation and referral of incidents of suspected fraud to the SIU;

(C) identification and recognition of red flags or red flag events;

(D) any changes to current procedures for identifying, documenting and referring incidents of suspected insurance fraud to the SIU;

(E) Fraud Division insurance fraud reporting requirements; and

(F) introduction/review of existing and new, emerging insurance fraud trends.

(3) The SIU personnel shall receive continuing anti–fraud training that includes;

(A) investigative techniques;

(B) communication with the Fraud Division and authorized governmental agencies;

(C) fraud indicators;

(D) emerging fraud trends; and

(E) legal and related issues.

(d) Records of the anti–fraud training provided to all staff shall be prepared at the time training is provided and be maintained and available for inspection by the Department on request. The training records shall in-

clude the title and date of the anti–fraud training course, name and title and contact information of the instructor(s), description of the course content, length of the training course, and the name and job title(s) of participating personnel.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2004, No. 36).
5. New section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. New section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. New section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.40. SIU Annual Report.

(a) Each insurer shall file a report as prescribed herein, at the time its initial Certificate of Authority is issued, and annually thereafter. The annual report shall be due no later than 90 days after the date of mailing of the notification by the Department. The Department shall issue the notification in June of each year.

(b) A complete, accurate and truthful annual report shall be submitted on a form as prescribed by the Department and shall include the following information.

(1) The name(s), title(s) and contact information of the insurer's SIU personnel; or

(2) The name of the organization and organizational contacts with whom the insurer has contracted for the maintenance of the SIU or any function thereof; and

(3) The names of personnel whose duties include communication with the Fraud Division on matters related to the reporting, investigation and prosecution of suspected fraudulent claims or other suspected insurance fraud.

(4) A description of the insurer's methods and written procedures used for detecting, investigating and reporting suspected insurance fraud.

(5) A description of the insurer's plan for initial and on–going fraud education and training for integral anti–fraud personnel pursuant to these regulations.

(6) A written description or chart outlining the organizational arrangement of the insurer's anti–fraud personnel who are responsible for the investigation and reporting of suspected insurance fraud.

(7) A description of how the SIU is adequately staffed to meet the requirements herein and the expertise of the staff.

(8) The number of claims processed by the insurer and the number of claims referred to the SIU, for each reported company, for the past calendar year.

(9) The number of incidents of suspected insurance fraud reported to the Department and to district attorney offices, for each reported company, for the past calendar year.

(10) A description of any significant, anticipated changes to the insurer's structure and operations.

(11) Insurers who enter into contracts for the purpose of compliance with these regulations shall provide a complete copy of the fully executed, existing contract, including all attachments and addendum, to the Department and shall specify the manner in which the contract is monitored.

(12) The number and type of civil actions initiated by each reported company alleging acts of insurance fraud during the preceding calendar year.

(c) A statement signed under penalty of perjury pursuant to the laws of the state of California, must accompany all reports mentioned herein. This statement must be signed by an officer of the holder of or applicant for the Certificate of Authority who attests to the accuracy of the reported information and the signor's personal knowledge of the existence and proper maintenance of an SIU described in this report and these regulations.

(d) The insurer is to maintain a copy of the annual report that will be available for review during examinations as conducted pursuant to section 2698.41 of these regulations or as otherwise requested by the Department.

(e) For the purpose of these regulations, the name(s) of the insurer's personnel who will communicate with the Fraud Division shall not be made part of the public record and shall be released only pursuant to the provisions of CIC Section 1873.1 applicable to information acquired pursuant to Article 3 of the Insurance Frauds Prevention Act.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New article and section filed 5–3–94; operative 6–2–94 (Register 94, No. 18).
2. Repealer of article 2 (sections 2698.40–2698.45) and repealer and new section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Repealer of article 2 (sections 2698.40–2698.45) and repealer and new section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
4. Repealer of article 2 (sections 2698.40–2698.45) and repealer and new section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2004, No. 36).
6. Repealer of article 2 (sections 2698.40–2698.45) and repealer and new section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
7. Repealer of article 2 (sections 2698.40–2698.45) and repealer and new section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Repealer of article 2 (sections 2698.40–2698.45) and repealer and new section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.41. Examinations.

(a) The commissioner may conduct examinations of an insurer's SIU and related operations, including operations undertaken by entities under contract with the insurer, as deemed necessary to determine compliance with the requirements of this article.

(b) A written report of examination, including identification of violations of these applicable provisions of statute and regulation and required corrective action, if any, will be provided to the insurer on completion of the examination.

(c)(1) Notwithstanding any penalty imposed pursuant to the regulations, within thirty (30) days of receipt of a written report identifying any violation(s) of these regulations, an insurer shall submit to the Department a plan demonstrating how the insurer will correct such violation(s) and achieve compliance. Such plan shall be subject to examination by the Department. If accepted by the Department, the plan shall be submitted as a supplement to any existing annual report and shall be accompanied by a statement of an officer of the insurer as otherwise required for annual reports. Failure to submit a corrective action and compliance plan or to comply with such plan when accepted by the Department shall be considered a violation of these regulations.

(2) Any insurer submitting a written report pursuant to Subsection 2698.41(c)(1) setting forth a corrective action plan may also submit any of the following information to the Commissioner in conjunction with the report required by Subsection 2698.41(c)(1):

(A) any written material that may rebut any matters contained in the examination report.

NOTE: Authority cited: Sections 730 et. seq, 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 5–3–94; operative 6–2–94 (Register 94, No. 18).
2. Repealer and new section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Repealer and new section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
4. Repealer and new section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2004, No. 36).
6. Repealer and new section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
6. Repealer and new section refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
7. Repealer and new section refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as 4–29–2005 order, including repealer and new section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.42. Penalties.

(a) If the Commissioner acts pursuant to the provisions of California Insurance Code Section 1875.24(c) or (d) and finds that the insurer has failed to comply with the provisions of this article, the Commissioner shall impose a monetary penalty in an amount not to exceed $5,000 for each act of non–compliance. Where the Commissioner determines that an insurer has willfully failed to comply with this article, the Commissioner may impose a monetary penalty in an amount not to exceed $10,000 for each willful act of non–compliance. The Commissioner shall consider the factors enumerated at California Code of Regulations Title 10 Chapter 5, Subchapter 3,Section 2591.3(a)–(f) and determine if any of the enumerated factors are applicable to the insurer's conduct in the establishment and operation of its special investigative unit. If the Commissioner finds such factors are applicable to the insurer's conduct, the Commissioner may reduce the amount of the monetary penalty prescribed in subsection 2698.42(a).

(b) If the Commissioner acts pursuant to the provisions of California Insurance Code Section 1875.24(c) or (d) and determines that the acts of non–compliance are inadvertent and are solely relative to the maintenance and operation of the special investigative unit of the insurer, then the Commissioner shall consider such violations to be a single act for the purposes of imposition of a monetary penalty that is no greater than $5,000 for that single act. For all other inadvertent acts, the Commissioner shall impose a penalty in the amount of up to $5,000 per inadvertent act that is not in compliance with this article.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 5–3–94; operative 6–2–94 (Register 94, No. 18).
2. Repealer and new section filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Repealer and new section refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
4. Repealer and new section refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2004, No. 36).
6. Repealer and new section refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section as it existed prior to 9–4–2003 emergency action by operation of Government Code section 11346.1(f) (Register 2004, No. 53).
8. Repealer filed 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
9. Repealer refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as 4–29–2005 order, including new section heading and section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.43. Hearings.

(a) Any hearing conducted pursuant to these regulations shall be governed by the provisions of California Government code Section 11425.10(a).

(b) The Commissioner shall give 30 days written notice of any hearing held pursuant to these regulations.

NOTE: Authority cited: Section 11425.10(a), Government Code; Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Section 11425.10(a), Government Code; and Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

HISTORY

1. New section filed 5–3–94; operative 6–2–94 (Register 94, No. 18).
2. Repealer filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
4. Repealer refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2004, No. 36).

6. Repealer refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
7. Repealer refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Repealer refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as 4–29–2005 order, including new section heading and section, transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.44. Oversight of Special Investigative Unit Maintenance and Operations.

NOTE: Authority cited: Sections 1872, 1875.20, 1875.21, 1875.22 and 1875.23, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 1247; *Garris v. Carpenter* (1939) 33 Cal. App. 2d 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.22 and 1875.23, Insurance Code.

HISTORY

1. New section filed 5–3–94; operative 6–2–94 (Register 94, No. 18).
2. Repealer filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Repealer refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
4. Repealer refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2004, No. 36).
6. Repealer refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
7. Repealer refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
8. Repealer refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as 4–29–2005 order transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

§ 2698.45. Penalties.

NOTE: Authority cited: Sections 700, 704, 704.7, 1872, 1875.20, 1875.21, and 1875.22, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.22 and 1875.23, Insurance Code.

HISTORY

1. New section filed 5–3–94; operative 6–2–94 (Register 94, No. 18).
2. Change without regulatory effect amending subsection (c), filed 3–19–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 12).
3. Repealer filed 9–4–2003 as an emergency; operative 9–4–2003 (Register 2003, No. 36). A Certificate of Compliance must be transmitted to OAL by 1–2–2004 or emergency language will be repealed by operation of law on the following day.
4. Repealer refiled 1–2–2004 as an emergency; operative 1–3–2004. (Register 2004, No. 1). A Certificate of Compliance must be transmitted to OAL by 5–3–2004 or emergency language will be repealed by operation of law on the following day.
5. Repealer refiled 5–4–2004 as an emergency; operative 5–4–2004 (Register 2004, No. 19). A Certificate of Compliance must be transmitted to OAL by 9–1–2004 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2004, No. 36).
7. Repealer refiled 9–1–2004 as an emergency; operative 9–1–2004 (Register 2004, No. 36). A Certificate of Compliance must be transmitted to OAL by 12–30–2004 or emergency language will be repealed by operation of law on the following day.
8. Repealer refiled 12–28–2004 as an emergency; operative 12–30–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–29–2005 or emergency language will be repealed by operation of law on the following day.
9. Repealer refiled 4–29–2005 as an emergency; operative 4–29–2005 (Register 2005, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–29–2005 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as 4–29–2005 order transmitted to OAL 8–26–2005 and filed 10–7–2005 (Register 2005, No. 40).

Article 3. Program for Investigation and Prosecution of Workers' Compensation Insurance Fraud.

§ 2698.50. Authority and Purpose.

These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of Section 1872.83 of the California Insurance Code. The purpose of these regulations is to set forth the criteria for distribution of funds to district attorneys for enhanced investigation and prosecution of workers' compensation insurance fraud cases, including an application process and subsequent reporting requirements.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1872.83 and 1872.9, Insurance Code.

HISTORY

1. New article 3 and section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).

§ 2698.51. Definitions.

For the purposes of these regulations:

(a) "Application" means the written document submitted to the Commissioner by which a local district attorney requests program funding, including a plan setting forth the district attorney's intended use of funds to enhance investigation and prosecution of workers' compensation insurance fraud.

(b) "Assessment" means the surcharge collected from insurers and self–insured employers to support the program to enhance investigation and prosecution of workers' compensation fraud.

(c) "Case" means the file set up by the California Department of Insurance Fraud Division (formerly, the Bureau of Fraudulent Claims) and/or the California Department of Insurance Investigations Bureau, and/or district attorney in the course of and for the purpose of investigation, development of evidence and prosecution of individual or consolidated activities of suspected workers' compensation fraud.

(d) "Claim" means the request for payment of workers' compensation benefits which has been submitted to an insurer as defined in Section 1877.1(c) of the Insurance Code.

(e) "Commissioner" means the Insurance Commissioner of the state of California.

(f) "County Plan" means the plan submitted to the Commissioner as part of the application process by the local district attorney which details the projected use of the funds sought pursuant to these regulations.

(g) "Department" means the California Department of Insurance.

(h) "District Attorney" means the prosecuting officer of a California county jurisdictional district.

(i) "Division" means the California Department of Insurance Fraud Division, formerly known as the Bureau of Fraudulent Claims. The former Bureau was designated a Division subsequent to the implementation of CIC sections 1872.8 *et seq.* The California Department of Insurance Investigations Bureau is responsible for investigating premium fraud.

(j) "Incidental Expenses" means those costs incurred by the California Department of Insurance and the California Department of Industrial Relations to administer the program and may include Fraud Assessment Commission expenses, costs of collection of assessments, administrative

support of the Fraud Division program component, management of the distribution and oversight of monies allocated to the district attorneys.

(k) "Local Program Funding" means that portion of the funds collected and distributed to district attorneys pursuant to section 1872.83 of the Insurance Code.

(*l*) "Premium Fraud", also commonly called "employer fraud", are those acts of fraud, including and not limited to under-reporting payroll, misclassification of employees' duties, experience modification evasion, committed by or at the direction of an employer, for the purpose and with the effect of reducing premium liability.

(m) "Program" means those activities conducted by the Department, the Department of Industrial Relations, and any other agency which are necessary to fund or administer enhanced investigation and prosecution of workers' compensation insurance fraud through assessments on insurers as defined in Section 1877.1(c) of the Insurance Code and the distribution of funds to the Fraud Division to district attorneys for the purpose of investigation and prosecution of workers' compensation insurance fraud.

(n) "Regulations" means these regulations, California Code of Regulations, Title 10, Chapter 5, Subchapter 9, Article 3.

(o) "Suspected Fraudulent Claim" means a claim referred to the Fraud Division because the insurer, employer or claims administrator suspects, knows or reasonably believes that the claim involves a person who has committed a fraudulent act related to workers' compensation insurance.

NOTE: Authority cited: Section 1872.83, Insurance Code: *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1872.83 and 1872.9, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).
2. Change without regulatory effect amending subsection (n) filed 11–9–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 46).

§ 2698.52. Application Procedure.

(a) A Request for Application (RFA) shall be distributed annually on or before April 1, to each county district attorney in the state and shall include county data indicators, as outlined in Section 2693.5, which form the basis for each district attorney's base allocation.

(b) The RFA shall specify a deadline for submission of applications to the Commissioner, which shall be 30 days after distribution of the RFA.

(c) Any district attorney who fails to submit an application, or whose application is not received by the Commissioner at the address specified in the RFA, by the deadline date and time set forth in the RFA, shall not be considered for funding.

(d) Applications for funding submitted by the district attorneys shall list the County Plan and budget elements as outlined in Section 2693.6 and shall include a Table of Contents to facilitate plan review.

(e) Two or more counties may coordinate planning and submit applications addressing a multi-county area so long as each individual county plan identifies its proportion of the budget.

(f) At such time as the Fraud Assessment Commission makes funds available through initiating an assessment to augment fund availability, the Review Panel, as established by section 2698.52(f) of these regulations, shall analyze applications for the purpose of assisting the Commissioner in making funding determinations using the criteria set forth in section 2698.54 of these regulations. The Commissioner shall make his or her determination and shall obtain the advice and consent of the Fraud Division and the Fraud Assessment Commission, as to the most effective distribution of moneys.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).
2. Amendment of subsection (c) filed 3–30–2006 as an emergency; operative 3–30–2006 (Register 2006, No. 13). A Certificate of Compliance must be transmitted to OAL by 7–28–2006 or emergency language will be repealed by operation of law on the following day.
3. Amendment of subsection (c) refiled 7–28–2006 as an emergency; operative 7–28–2006 (Register 2006, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–27–2006 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–28–2006 order transmitted to OAL 11–22–2006 and filed 1–8–2007 (Register 2007, No. 2).

§ 2698.53. Funding Procedure.

(a) Funding shall be in the form of a Grant Award Agreement and shall require an enabling resolution approving and authorizing execution of the agreement by the county Board of Supervisors.

(b) Funding shall be distributed on an annual basis in July and funding shall be contingent upon the adoption of each annual State Budget Act and the collection of assessments.

(c) Any portion of distributed funds not used for local program purposes at the termination of each program period as specified in the Request for Application shall be returned to the Workers' Compensation Fraud Account in the Insurance Fund to be reprogrammed for use in the subsequent program year for local program purposes. Counties shall provide the Department with an estimate of unused funds within sixty (60) days after the termination of the program period and shall complete the transfer of funds to the Insurance Fund within thirty (30) days after the completion of the final audit.

(d) A district attorney who has undertaken investigations and prosecutions which will continue into a subsequent year may carry over into the subsequent year distributed but unused funds not exceeding twenty-five percent (25%) of the total annual finding, provided that the district attorney specifies and justifies in writing to the Commissioner how those funds will be used (1) at the end of the program period and (2) at the time of the subsequent application. In the event that distributed, but unused, funds exceed twenty-five (25%) of the previous total annual funding, due to extenuating circumstances, the Commissioner shall consider and approve requests for carry-over to the extent that the district attorney provides justification.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).
2. Amendment of subsection (b) filed 3–30–2006 as an emergency; operative 3–30–2006 (Register 2006, No. 13). A Certificate of Compliance must be transmitted to OAL by 7–28–2006 or emergency language will be repealed by operation of law on the following day.
3. Amendment of subsection (b) refiled 7–28–2006 as an emergency; operative 7–28–2006 (Register 2006, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–27–2006 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–28–2006 order transmitted to OAL 11–22–2006 and filed 1–8–2007 (Register 2007, No. 2).

§ 2698.54. Criteria for Distribution of Funds to the District Attorneys.

Each district attorney's allocation shall consist of two parts: a base allocation and a program award, both made as a result of the evaluation of the county plans. The base allocation shall be made from fifty percent (50%) of the total funds and allocated according to the following "caseload estimate", an estimate of the district attorney's proportional share of the state's workers' compensation fraud investigation and prosecution caseload:

(a) The county's proportion of the state's annual average number of workers engaged in wage and salary employment for the most recent year of report shall receive the greatest weight and shall account for sixty-six percent (66%) of the base allocation funding. The employment data source is the Employment Development Department Annual Planning Information.

(b) The county's proportion of the state's workers' compensation suspected fraudulent claims as reported to the California Department of Insurance over the previous three years shall account for thirty-four percent (34%) of the base allocation funding. The source for data on the number of suspected fraudulent claims reported to the Division is the California Department of Insurance.

[The next page is 752.9.]

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).
2. Change without regulatory effect amending section heading filed 12–13–93 pursuant to section 100, title 1, California Code of Regulations (Register 93, No. 51).

§ 2698.55. County Plan.

Each district attorney's program award shall be based on the evaluation of the County Plan. The County Plan shall be evaluated by a Review Panel to be comprised of two members of the Fraud Assessment Commission, the Chief of the Fraud Division or his or her designee, the Director of the Department of Industrial Relations or his or her designee, and an expert in consumer crime investigation and prosecution to be designated by the Commissioner.

The County Plan shall include but need not be limited to the following elements detailing the county's qualifications and the manner in which the district attorney will use the funds to investigate and prosecute workers' compensation insurance fraud:

(a) Qualifications.

(1) A description of the district attorney's experience in investigating and prosecuting workers' compensation insurance fraud. Relationships with other public or private entities which may be useful to the program should also be included.. Specific activity during the past two years should be detailed as follows:

(A) Number of investigations initiated, specifying number of identified suspects per investigation;

(B) Number of warrants or indictments issued, specifying number of suspects and/or defendants;

(C) Number of arrests made;

(D) Number of convictions obtained, specifying number of defendants, number obtained by trial verdict and number obtained by plea or settlement;

(E) Amount of fines and penalty assessments ordered and collected, specifying number of defendants; and

(F) Amount of restitution ordered and collected, specifying number of defendants and victims.

(2) The panel shall consider each applicant county's population size in proportion to its historic commitment of resources to insurance fraud investigation and prosecution.

(b) Plan. The district attorney's plan for investigation and prosecution of workers' compensation fraud, including, at a minimum, the following elements:

(1) Problem Statement. A description of the extent and nature of the problem in the county, including its sources and causes, its economic and social impact, its unique aspects, if any, and what is needed to resolve the problem. Supporting data, evidence, or indicators of fraudulent activity related to workers' compensation insurance should be included. The data and information may be derived from third party administrators, self–insured employers, other local law enforcement entities, insurers or the Fraud Division or the Investigation Bureau of the California Department of Insurance.

(2) Program Strategy. This section shall specify how the district attorney will use prgram funds to address the problem defined above including:

(A) Outreach. A description of the manner in which the district attorney will develop his or her caseload, the source(s) for referrals of cases for investigation and/or prosecution, whether directly from the Division and/or directly from self–insured employers, third–party administrators and insurers or a combination;

(B) Personnel. The number, position titles and position justification of personnel to be funded fully or in part through grant funds, including descriptions of the qualifications of personnel to be assigned to the program and an organization chart identifying positions to be funded;

(C) Program Coordination. A description of the manner in which the district attorney plans to coordinate involved sectors, including employers, insurers, medical and legal provider communities, the Fraud Division and the Investigation Bureau of the California Department of Insurance;

(D) Management Plan. The detailed plan and schedule of the steps the district attorney will complete in achieving the objectives of the program and a discussion of how the program will be organized and what internal quality control and budget monitoring procedures will be employed. This part should also include how this program will be integrated with any other anti–fraud program(s) maintained within the district attorney's office;

(E) Staff Development. The plan for ongoing training of personnel on the workers' compensation system and the investigation and prosecution of fraud. Staff development may be addressed through coordination with the Division insurers or other entities.

(3) Objectives. This section shall outline the district attorney's anticipated achievements in the following areas:

(A) Estimated number of investigations to be initiated during the grant period, including a separate estimate of the number resulting from carryover investigations; and

(B) Estimated number of prosecutions to be initiated during the grant period.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).

§ 2698.56. Budget Proposal.

The proposed budget forms the basis for program management and audit and must be presented in line–item detail and cover the period from July 1 through June 30. The budget may include a line item for an independent audit to be completed at the end of the program period. The district attorney's budget shall include, but need not be limited to, the following:

(a) Those salaries and benefits which are computed at the county salary and benefit schedule.

(b) Operation support costs.

(1) Estimated costs shall be listed by line item.

(2) Itemized costs shall conform to county policy regarding appropriateness of expenditures.

(3) Allowable costs are those costs incurred in district support of local program activities, including program related travel, equipment costs proportional to their program–related use, facilities cost, expert witness fees, audits.

(c) Indirect costs, including those costs not readily itemized but necessary to the local program operation may not exceed ten percent (10%) of personnel salaries (excluding benefits and overtime) or five percent (5%) of total direct program costs (excluding equipment). Counties must have on file an approved indirect cost allocation plan specifying how the rate was established, supported by formal accounting records to substantiate the charges. Indirect costs may not include any line item charged as a direct cost.

(d) Non–allowable budget items include:

(1) Real property purchases ands improvements;

(2) Aircraft or motor vehicles, except the purchase of motor vehicles which is specifically justified to the Commissioner;

(3) Interest payments;

(4) Food and beverages, except as purchased in connection with program–related travel;

(5) Weapons or ammunition unless included as part of a benefit package.

(e) Program funds must be used to support enhanced investigation and prosecution of workers' compensation insurance fraud and shall not be used to supplant funds which, in the absence of program funds, would be made available for any portion of the local workers' compensation insur-

ance fraud program. Budget modifications are allowable so long as they do not change the grant award amount.

(f) Budget modifications are allowable so long as they do not change the grant award amount.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).
2. Amendment of subsection (c) filed 3–30–2006 as an emergency; operative 3–30–2006 (Register 2006, No. 13). A Certificate of Compliance must be transmitted to OAL by 7–28–2006 or emergency language will be repealed by operation of law on the following day.
3. Amendment of subsection (c) refiled 7–28–2006 as an emergency; operative 7–28–2006 (Register 2006, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–27–2006 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–28–2006 order, including further amendment of subsection (c), transmitted to OAL 11–22–2006 and filed 1–8–2007 (Register 2007, No. 2).

§ 2698.57. Funding Recommendations.

Based on the Review Panel's evaluation of each County Plan, the Panel will forward funding recommendations to the Commissioner. If the County Plan fails to respond adequately to the required items as specified in Sections 2693.6 and 2693.7, the Panel may recommend funding at the district attorney's base allocation level; however, the Panel shall consider the importance of establishing a program presence in a county to increase community awareness and deter workers' compensation fraud. However, Applications which fail to meet the specified criteria may be recommended for no funding.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).

§ 2698.58. Fraud Assessment Commission Review and Consent.

(a) Before funds can be distributed to the District Attorneys, the Commissioner shall make a determination, based on the recommendation of the Review Panel and with the advice and consent of the Fraud Division as to the most effective distribution of moneys, and shall forward his or her decision on the funding distribution to the Chair of the Fraud Assessment Commission within five business days of the date of the Review Panel's recommendation on funding for the Commission's advice on and consent to the funding distribution. The Fraud Assessment Commission shall notify the Commissioner in writing within ten business days of receipt of the Commissioner's decision whether it agrees or if it does not agree with the recommended funding distribution.

(b) In the event that the Commission does not agree with the Commissioner's recommended funding distribution, the Commission shall set forth, in writing, the basis upon which its consent has been withheld and shall forward such written decision to the Commissioner within ten business days along with a written request for reconsideration. If the Commission indicates that it does not agree with the Commissioner's funding distribution, the Commissioner shall reconsider the distribution based upon the written advice of the Commission.

(c) After reconsideration of the distribution, the Commissioner shall forward to the Commission, within ten business days, his or her written recommendation upon reconsideration. If the Commission withholds its consent to the Commissioner's reconsidered funding distribution, the Commission shall set forth, in writing, the basis upon which its consent has been withheld and shall forward such written decision within ten business days, along with a request for submission of a revised County Plan, to the District Attorney(s) submitting the disapproved County Plan.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).
2. Change without regulatory effect amending subsection (c) filed 12–13–93 pursuant to section 100, title 1, California Code of Regulations (Register 93, No. 51).

§ 2698.59. District Attorney Reporting.

Each district attorney receiving regular annual funds and/or augmentation funds pursuant to Section 1872.83 shall submit an annual report at the close of the regular annual funding program period, within the deadlines specified in subsection (d), below, to the Commissioner on the local program and its accomplishments. Failure to submit the annual report shall be considered in subsequent funding decisions. At a minimum the report shall include the following items:

(a) An Expenditure Report, which shall include the following:

(1) Personnel: salaries and benefits.

(2) Operations cost breakdown.

(3) Explanation of any significant variances from the district attorney's plan as approved.

(b) A financial report prepared by an independent auditor who is a qualified state or local government auditor or independent public accountant licensed by the State of California or the County Auditor Controller. The audit report shall certify that local expenditures were made for the purposes of the program as specified in Section 1872.83 of the Insurance Code, the regulations as adopted, the guidelines in the Request for Application, and the County Plan.

(1) The auditor shall use county policies and procedures as the standard for verifying appropriateness of personnel and support costs.

(2) In the event the program audit is included as part of an organization–wide audit, revenues and expenditures for the local program must be shown separately.

(c) A Program Report, which shall include the following:

(1) Number of investigations initiated related to workers' compensation insurance fraud, with number of defendants indicated;

(2) Number of arrests or civil suit filings related to workers' compensation insurance fraud, with number of defendants indicated;

(3) Number of convictions or civil awards related to workers' compensation insurance fraud, with number of defendants, number of trials, number of pleas and/or settlements indicated;

(4) Dollar savings realized as a result of workers' compensation insurance fraud case prosecutions, including fines and penalty assessments ordered and collected and restitution ordered and collected, with number of defendants indicated;

(5) Summary of activity with respect to pursuing a reduction of workers' compensation fraud in coordination with the following:

(A) Fraud Division.

(B) Insurance companies.

(C) Employers, as defined in Section 3300 of the Labor Code, who are self–insured for workers' compensation and doing business in the state.

(d) The deadlines for submission are as follows:

(1) Expenditure Reports and Audit Reports must be submitted to the Commissioner no later than four (4) months after the close of the program period as specified in the Request for Application. A county may report an extension of time for the submission of the Expenditure and/or Budget Report in the event an organization–wide audit will delay the submission of either or both of the said reports.

(2) Program Reports must be submitted to the Commissioner no later than two months after the close of the program period as specified in the Request for Application.

(e) There shall be a grant liquidation period for ninety (90) days following the termination of the program period during which costs incurred but not paid may be paid and deducted from the program budget.

(f) The Commissioner may perform such additional audits or reviews of any local program as he or she may deem necessary and shall have access to all reports, working papers, correspondence, or other documents, including audit reports and audit working papers related to the audit report or local program.

NOTE: Authority cited: Section 1872.83, Insurance Code; *CalFarm Insurance Company, et al.* v. *Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.83, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–8–93 (Register 93, No. 41).

Article 4. Program for Investigation and Prosecution of Automobile Insurance Fraud

§ 2698.60. Authority and Purpose.

These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of Section 1872.8 of the California Insurance Code. The purpose of these regulations is to establish the level of annual assessment per insured vehicle in the state and to set forth the intended and allowable use of funds to be distributed to district attorneys for purposes of investigation and prosecution of automobile insurance fraud, including an application process and subsequent reporting requirements.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New subchapter 9, article 4 and section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).

§ 2698.61. Definitions.

For the purposes of these regulations:

(a) "Application" means the written document submitted to the Commissioner by which a local district attorney requests program funding, including a plan setting forth the district attorney's intended use of funds to enhance the investigation and prosecution of automobile insurance fraud.

(b) "Assessment" means the annual fee paid by insurers for each vehicle insured under an insurance policy in the state to support enhanced investigation and prosecution of automobile insurance fraud.

(c) "Case" means the file set up by the Division or district attorney(s) of the suspected fraudulent claims for the purpose of investigation, development of evidence and prosecution.

(d) "Claim" means the request for payment of automobile insurance benefits which has been submitted to an insurer.

(e) "Commissioner" means the Insurance Commissioner of the state of California.

(f) "County Plan" means the plan submitted to the Commissioner as part of the application process by the local district attorney which details the projected use of the funds sought pursuant to these regulations.

(g) "Department" means the California Department of Insurance.

(h) "District Attorney" means the prosecuting officer of a California county jurisdictional district as provided in Government Code section 26500.

(i) "Fraud Division" or "Division" means the California Department of Insurance Fraud Division, formerly known as the Bureau of Fraudulent Claims. The Bureau was designated the Fraud Division subsequent the to the enactment of CIC Section 1872.8.

(j) "Grantee" means a grant–funded applicant.

(k) "In force" means an insurance policy, covering note or binder that has been issued and put into effect on a vehicle in this state.

(*l*) "Incidental Expenses" means those costs incurred by the California Department of Insurance to administer the program and may include reasonable costs for collection of assessments, administrative support of the Fraud Division program component, management of the distribution and oversight of monies allocated to the district attorneys.

(m) "Program" means those activities conducted by the Department, or any other agency, which are directed toward the enhanced investigation and prosecution of automobile insurance fraud and which require funding or administration through assessments and the distribution of

funds to the Fraud Division, Department of California Highway Patrol and to district attorneys.

(n) "Insurer" shall have the same meaning as used in California Insurance Code section 23.

(o) "Regulations" means these regulations, California Code of Regulations Title 10, Chapter 5, Subchapter 9, Article 4.

(p) "Suspected Fraudulent Claim" means a claim which has been referred to the Division because the insurer reasonably believes that the claim involves a person who has committed a fraudulent act related to automobile insurance.

(q) "Transaction Date" means the date, by month, day and year, on which a vehicle is added to the Automobile Assessment File.

(r) "Vehicle" shall have the same meaning as defined in Section 670 of the Vehicle Code and shall include commercial and non–commercial vehicles.

(s) "Vehicle identification number (VIN)" means a series of Arabic number and Roman letter that is assigned to a motor vehicle by its manufacturer for identification purposes.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).
2. Amendment of subsections (b) and (h), new subsections (j), (m) and (p), subsection relettering and amendment of newly designated subsection (*l*) filed 10–12–2001; operative 11–11–2001 (Register 2001, No. 41).
3. New subsections (k), (q) and (s) and subsection relettering filed 6–3–2005; operative 7–3–2005 (Register 2005, No. 22).

§ 2698.62. Setting of the Annual Fee.

(a) Each insurer will be assessed and will pay a fee of twenty–five ($.25) cents per vehicle for each quarter of a calendar year or any part thereof that it insures under a policy of insurance issued in this state. The assessment shall be made as provided in paragraph (b) of this section.

(b) The Commissioner will invoice for the assessment specified in subsection (a) quarterly. The assessment shall be due on each vehicle, identified by its vehicle identification number for each quarter that a policy is in force on such vehicle and when a vehicle is added to or replaces one under an existing policy. Each quarterly assessment payment shall be submitted with a certification by an Officer of the insurer, under penalty of perjury under the laws of the State of California, that the number of vehicles reported therein is accurate and has been calculated in conformity with these regulations. The insurer shall, on request by the Commissioner, provide verification of the number of vehicles insured under a policy of insurance.

(c) Subject to the prior written approval of the department, an insurer may use a method to identify the vehicles subject to this assessment other than provided in subsection (b) if, prior to using such methodology, the insurer:

(1) demonstrates that it can not identify the vehicles it insures in this state by their individual vehicle identification number;

(2) submits a detailed description of proposed method,

(3) demonstrates the proposed alternative method is as accurate a method as that described in subsection (b) of this section, and

(4) agrees to use any method approved under this subsection until another method may otherwise be approved in writing by the department.

(d) In order to verify of the number of vehicles for which an assessment is due and has been paid under this section, each insurer shall maintain a file known as the Automobile Assessment File. The Auto Assessment File shall contain the vehicle identification, policy number and transaction date for every vehicle for which a policy of insurance was in force for each quarter or any part thereof. For group insurers, the information shall be maintained on an individual company basis. The data shall be kept in a computer format that allows for the insurer to place each calender year quarter data on a computer media format in a format specified by the Commissioner. The data in the file shall be kept for a minimum of five years after each calendar year quarter.

(e) A separate assessment need not be paid on a vehicle insured on:

(1) A renewal policy issued within the same quarter of a calendar year, on the same vehicle by the same insurer or insurer with the same group.

(2) A multi–peril, umbrella or excess coverage policy where the vehicle is already covered under a primary policy.

(3) A road–side or mechanical breakdown policy that does not provide coverage for collision or other–than–collision (comprehensive) losses.

(4) A vehicle for which a policy has been written but was not put in force.

(f) Payment of the assessment shall be considered delinquent if not paid by the insurer within forty–five (45) days of the invoice date. Any amount not paid within this period shall be charged a late fee in accordance with CIC section 12995.

(g) Notwithstanding subdivision (a) of this section, if the Commissioner determines that the amount to be collected will exceed the amount to be expended from the annual Budget Act appropriation to fund the program under this article, the Commissioner may discount the amount of the assessment to be collected to more closely meet the expenditures authorized by the annual Budget Act.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1872.8 and 12995, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).
2. Repealer and new section and amendment of NOTE filed 10–12–2001; operative 11–11–2001 (Register 2001, No. 41).
3. Editorial correction of subsections (a), (c) and (e) (Register 2001, No. 45).
4. Repealer of subsections (a)–(b), new subsections (a)–(d), subsection relettering, amendment of newly designated subsections (e) and (f) and new subsection (e)(4) filed 6–3–2005; operative 7–3–2005 (Register 2005, No. 22).

§ 2698.63. Application Procedure.

(a) A Request for Application (RFA) shall be distributed annually to each county district attorney in the state.

(b) The RFA shall specify a deadline for submission which shall be 30 days after distribution.

(c) Any district attorney who fails to submit an application, or whose application is not received by the Commissioner at the address specified in the RFA, by the close of business on the deadline date set forth in the RFA, may be subject to delay in receiving any funding award. Any district attorney from whom an application is not received within the ninety day period following the deadline set forth in the RFA shall not be considered for funding.

(d) Applications for funding submitted by the district attorneys shall list the County Plan and budget elements as outlined in Section 2698.65 and shall include a Table of Contents to facilitate plan review.

(e) Two or more counties may coordinate planning and submit plans addressing a multi–county area so long as each individual county plan identifies that county's proportion of the budget.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).

§ 2698.64. Funding Procedure.

(a) Funding shall be in the form of a Grant Award Agreement and shall require an enabling resolution by the county Board of Supervisors approving and authorizing execution of the agreement.

(b) Subsequent to the initial grant award, funding shall be distributed on a semi–annual basis, in July and January unless otherwise specified and justified in the Request for Application by the district attorney and contingent upon the adoption of each annual State Budget Act and the collection of assessments.

(c) Any portion of distributed funds not used for local program purposes at the termination of each annual funding cycle shall be returned to the Insurance Fund to be reprogrammed for use in the subsequent program year for local program purposes. Counties shall provide the Department with an estimate of unused funds within sixty (60) days after the termination of the program period and shall complete the transfer of funds

back to the Insurance Fund within thirty (30) days after the completion of the final audit.

(d) A district attorney who has undertaken investigations and prosecutions which will carryover into a subsequent program year may carryover into the subsequent year distributed but unused funds not exceeding twenty–five percent (25%) of the total annual funding, provided that the district attorney files a written plan which specifies and justifies to the Commissioner how those funds will be used at the end of the program period and at the time of the subsequent application. In the event that, due to extenuating circumstances, distributed funds exceeding twenty–five percent (25%) of the previous total annual funding are unused, the Commissioner shall consider and approve requests for carry–over of the unused funds to the extent that the district attorney provides justification.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).

§ 2698.65. County Plan and Criteria for Distribution of Funds to the District Attorney Grantee.

In order to be considered for funding, the local district attorney must submit a plan outlining the projected and prior use of funds for the purposes of the program. Funds assessed after January 1, 1993 shall be distributed among these district attorneys who have submitted a plan. Seventy percent (70%) of available funds will be distributed based on the applicant's proportionate share of the state's population, twenty percent (20%) will be distributed based on the applicant's proportionate share of the automobile insurance suspected fraudulent claims submitted to the Fraud Division during the prior three years and ten percent (10%) will be based on the Commissioner's analysis of the County Plan. The plan must be submitted within the statutory time–frame and must include the following elements:

(a) Problem Statement. A description of the problem in the county, including how it arose, why it is important, its unique aspects, if any, and what is needed to resolve the problem, including supporting data, evidence, or indicators of fraudulent activity related to automobile insurance.

(b) Qualifications. A description of the applicant's experience in operating the auto insurance fraud program using funds authorized under Section 1872.8 of the Insurance Code since 1989 including:

(1) The total amount of funds received by the local district attorney since 1989.

(2) The total amount expended to support the district attorney's investigation and prosecution of auto insurance fraud, including details of the following items:

(A) Personnel costs including salaries and benefits.

(B) Operations expenses, including space, equipment, travel and other expenses in support of the program.

(3) The results obtained through implementation of the program, including:

(A) The number of investigations initiated or coordinated with other law enforcement agencies.

(B) The number of arrests and convictions.

(C) The number of indictments or complaints.

(D) A comparison of the amounts originally claimed in cases determined to be fraudulent compared to payments actually made.

(c) Program Strategy:

(1) Outreach. A description of the manner in which the district attorney will develop his or her caseload, the source(s) for referrals for cases for investigation or prosecution, whether directly from the Fraud Division or from other law enforcement agencies and/or insurers.

(2) Personnel. Justification for the number of personnel, position titles and position justification of personnel which will be funded fully or in part through grant funds, including descriptions of the qualifications of personnel to be assigned to the program and an organization chart identifying positions to be funded.

(3) Program Coordination. A description of the manner in which the district attorney plans to coordinate involved sectors, including insurers, medical and legal provider communities, auto repair facility operators, the Division, the California Highway Patrol, local law enforcement and community safety agencies.

(4) Management Plan. A detailed plan and schedule of the steps the district attorney will complete in achieving the objectives of the program and a discussion of how the program staff will be organized and what internal quality control and budget monitoring procedures will be employed. This part shall also include how this program will be integrated with any other anti–fraud program(s) maintained within the district attorney's office;

(5) Staff development. The plan for ongoing training of personnel on the investigation and prosecution of automobile insurance fraud. Staff development may be addressed through coordination with the Division, insurers, or other entities.

(d) Objectives. This section shall outline the district attorney's anticipated achievements in the following areas:

(1) Estimated number of investigations to be initiated during the grant period, including separate estimate of the number resulting from carryover investigations; and

(2) Estimated number of prosecutions to be initiated during the grant period.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).
2. Amendment of section heading, amendment of subsections (b) and (b)(3)(A)–(B) and amendment of NOTE filed 10–12–2001; operative 11–11–2001 (Register 2001, No. 41).

§ 2698.66. Budget Proposal.

The proposed budget forms the basis for program management and audit and must be presented in line–item detail and cover a one year program period from July through June. Annual budget levels shall be included in the RFA. The budget may include a line item for an independent audit to be completed at the end of each annual program period or as specified in the RFA. The district attorney's budget shall include the following:

(a) Salaries and benefits computed at the county salary and benefit schedule.

(b) Operation support costs.

(1) Estimated costs shall be listed by line item.

(2) Itemized costs shall conform to county policy regarding appropriateness of expenses.

(3) Allowable costs are those costs incurred in direct support of local program activities, including program related travel, equipment costs proportional to program–related use of the equipment, facilities cost, expert witness fees and audits.

(c) Indirect costs: indirect costs are those not capable of being assigned to a particular project or program, but necessary to the operation of the organization and the performance of the program. The costs of operating and maintaining facilities, accounting services, and administrative salaries are examples of indirect costs. Indirect costs shall not exceed 10 percent of personnel salaries (excluding benefits and overtime) or 5 percent of total direct program costs (excluding equipment).

(d) Non–allowable budget items include:

(1) Real property purchases and improvements.

(2) Aircraft or motor vehicles, except the purchase of motor vehicles which is specifically justified to the Commissioner.

(3) Interest payments.

(4) Food and beverages, except as purchased in connection with program–related travel. Food and beverages costs shall not exceed the applicant's per diem schedule.

(5) Weapons or ammunition unless included as part of a benefit package.

(e) Program funds must be used to support enhanced investigation and prosecution of insurance fraud and shall not be used to supplant funds which in the absence of program funds would be made available for any portion of the local automobile insurance fraud program.

(f) Budget modifications are allowable so long as they do not change the grant award amount.

(g) The annual and proposed use of these funds are subject to full public disclosure.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).
2. Amendment of subsections (c) and (d)(4) filed 10–12–2001; operative 11–11–2001 (Register 2001, No. 41).

§ 2698.67. District Attorney Reporting and Commissioner's Audit.

Each district attorney receiving funds pursuant to Section 1872.8 shall submit an annual report to the Commissioner regarding the local program and its accomplishments. Failure to submit the annual report shall affect subsequent funding decisions. The report shall include the following items:

(a) An expenditure Report, which shall include information for the following:

(1) Personnel: salaries and benefits.

(2) Operations cost breakdown.

(3) Explanation of any significant variances from the county's plan as approved.

(b) A financial audit report prepared by an independent, qualified state or local government auditor or independent public accountant licensed by the State of California or the county Auditor Controller. The audit report shall certify that local expenditures were made for the purposes of the program as specified in Section 1872.8 of the Insurance Code, these Regulations, the guidelines in the Request for Application and the County Plan.

(1) The auditor shall use county policies and procedures as the standard for verifying appropriateness of personnel and support costs.

(2) In the event that the program audit is included as part of an organization–wide audit, revenues and expenditures for the local program must be shown separately.

(c) Except as provided in this section, financial audits under this program shall be performed in accordance with the standards set forth in Government Accounting Standards Revised (August 1999) published by the Controller General of the United States, General Accounting Office. The above General Accounting Standards Revised (1999) are incorporated herein by this reference.

(d) A Program Report which shall include the following:

(1) The number of investigations initiated related to automobile insurance fraud.

(2) The number of arrests related to automobile insurance fraud.

(3) The number of prosecutions related to automobile insurance fraud.

(4) The number of convictions related to automobile insurance fraud.

(5) The dollar savings realized as a result of automobile insurance fraud case prosecutions.

(6) A summary of the activity directed toward the reduction of automobile insurance fraud with the following:

(A) Fraud Division.

(B) Insurance companies.

(e) The deadlines for submission are as follows:

(1) Expenditure Reports and Audit reports must be submitted to the Commissioner no later than four (4) months after the close of the program period as specified in the Request for Application. A county may request an extension in the event an organization–wide audit will delay submission of the audit.

(2) Program Reports must be submitted to the Commissioner no later than two (2) months after the close of the program period as specified in the Request for Application.

(f) There shall be a grant liquidation period of ninety (90) days following the termination of the program period during which costs incurred but not paid may be paid and deducted from the program budget.

(g) The Commissioner may perform such additional audits or reviews of any local program as he or she may deem necessary and shall have access to all working papers, correspondence, or other documents, including audit reports and audit working papers related to the audit report or local program.

(h) Notwithstanding any other provision of the law, the Commissioner shall perform a fiscal audit of the program administered under this section once every three years. The cost of a fiscal audit shall be shared equally between the department and the grantee.

NOTE: Authority cited: Section 1872.8, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Section 1872.8, Insurance Code.

HISTORY

1. New section filed 10–8–93; operative 11–7–93 (Register 93, No. 41).
2. Amendment of section heading and first paragraph, new subsections (c) and (h) and subsection relettering filed 10–12–2001; operative 11–11–2001 (Register 2001, No. 41).

§ 2698.68. Assessment of Annual Fee.

The fee imposed pursuant to California Insurance Code Section 1872.81 shall be calculated and assessed in the same manner as set forth in Section 2698.62 of this Title and will be paid in annualized increments of seven and one half cents ($.075) for each calendar year quarter or any part thereof.

NOTE: Authority cited: Section 1872.81, Insurance Code; *CalFarm Insurance Company et al. v. Deukmejian, et al.* (1989) 48 Cal.2d 805, 824. Reference: Section 1872.81, Insurance Code.

HISTORY

1. New section filed 6–24–2002; operative 7–24–2002 (Register 2002, No. 26).

Article 5. Organized Automobile Insurance Fraud Interdiction Program

§ 2698.70. Definitions.

For the purposes of these regulations:

(a) "Applicant" means one or more district attorneys.

(b) "Application" means a document submitted by an applicant for the purpose of requesting funding under this program.

(c) "Assessment" means an annual fee paid by insurers for each vehicle insured under an insurance policy in the state to support the enhanced interdiction of organized automobile fraud activity.

(d) "Commissioner" means the Insurance Commissioner of the California Department of Insurance.

(e) "Department" means the California Department of Insurance.

(f) "District Attorney" means the prosecuting officer of a California county as provided in Government Code section 26500.

(g) "Fraud Division" means the California Department of Insurance Fraud Division, also known as the Bureau of Fraudulent Claims.

(h) "Funding Cycle" means a consecutive 12–month period within a grant period. The funding cycle will commence with the first month of a grant period.

(i) "Grant Award" means an award of funds to be used by the Grantee pursuant to Insurance Code sections 1874.8 and 1874.81.

(j) "Grant Period" means a consecutive 36–month period commencing with the month as provided in a grant award.

(k) "Grantee" means a grant–funded applicant.

(l) "Insurer" shall have the same meaning as provided under California Insurance Code section 23.

(m) "Memorandum of Understanding" means a document, including any attachment or addendum, reflecting the agreed upon operational commitments and obligations between a grantee, the Fraud Division and the California Highway Patrol for a coordinated effort aimed at the inves-

tigation and prosecution of organized automobile fraud activity including a description of specific program objectives.

(n) "Organized automobile fraud activity" shall have the same meaning as set forth in Section 1874.8, subdivision (g) of the Insurance Code.

(o) "Program" means those activities conducted by the Fraud Division, the California Highway Patrol, and grantees which support the Organized Automobile Fraud Activity Interdiction Program.

(p) "Vehicle" shall have the same meaning as defined in Section 670 of the Vehicle Code and shall include commercial and non-commercial vehicles.

(q) "In force" means an insurance policy, covering note or binder that has been issued and put into effect on a vehicle in this state.

(r) "Vehicle identification number (VIN)" means a series of Arabic numbers and Roman letters that is assigned to a motor vehicle for identification purposes.

(s) "Transaction Date" means the date, by month, day and year, on which a vehicle is added to the Automobile Assessment File.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Section 26500, Government Code; and Sections 1874.8(a) and (g) and 1874.81, Insurance Code.

HISTORY

1. New article 5 (sections 2698.70–2698.77) and section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order, including amendment of subsection (m), transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).
3. Amendment of subsection (p) filed 12–26–2001 as an emergency; operative 12–26–2001 (Register 2001, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–25–2002 or emergency language will be repealed by operation of law on the following day.
4. Reinstatement of section as it existed prior to 12–26–2001 emergency amendment by operation of Government Code section 11346.1(f) (Register 2002, No. 23).
5. Amendment of subsection (p) filed 6–6–2002; operative 6–6–2002 pursuant to Government Code section 11343.4 (Register 2002, No. 23).
6. New subsections (q)–(s) filed 6–3–2005; operative 7–3–2005 (Register 2005, No. 22).

§ 2698.71. Annual Fee.

(a) Each insurer shall pay an annual fee of fifty cents ($.50) for each vehicle it insures under a policy of insurance issued in this state. This annual fifty cent fee shall be paid in increments of twelve and one-half cents ($.125) for each quarter of a calendar year or any part thereof. The assessment shall be made on a quarterly basis. The fee imposed pursuant to California Insurance Code Section 1874.8 shall be calculated and assessed in the same manner as set forth in title 10 California Code of Regulations section 2698.62.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Section 26500, Government Code; Sections 1874.8, 1874.81 and 12995, Insurance Code; and Section 670, Vehicle Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order, including amendment of section, transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).
3. Amendment filed 12–26–2001 as an emergency; operative 12–26–2001 (Register 2001, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–25–2002 or emergency language will be repealed by operation of law on the following day.
4. Reinstatement of section as it existed prior to 12–26–2001 emergency amendment by operation of Government Code section 11346.1(f) (Register 2002, No. 23).
5. Amendment filed 6–6–2002; operative 6–6–2002 pursuant to Government Code section 11343.4 (Register 2002, No. 23).
6. Amendment of subsection (a) and repealer of subsections (b)–(e) filed 6–3–2005; operative 7–3–2005 (Register 2005, No. 22).

§ 2698.72. Application Procedure and Contents.

(a) The Commissioner shall designate a date for the submission of an application requesting grant funding under this program. Notice of the date for submission shall be mailed to each district attorney at least 60 days before the date set for submission of an application. Applications received after the date set for submission will not be considered for funding.

(b) An application shall include:

(1) a "strategic plan" as more specifically described in section 2698.74.

(2) a "budget proposal" as more specifically described in section 2698.75.

(3) a list of program contacts for the applicant that shall include the name, position, business address, telephone and fax number for each individual.

(c) In addition to an application, each applicant shall submit as a separate document a memorandum of understanding.

(d) A joint application addressing a multi-county area may be submitted. Joint applications and accompanying documents as provided in subsection (a) shall, in addition to the items specified in subsection (b) of this section, address the use of funds by and between each participating county and designate a lead county for the purpose of receipt and distribution of the grant funding and to serve as the responsible entity for the administration of the grant.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Sections 1872.8(b)(1), 1874.8(d) and (e) and 1874.81, Insurance Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).

§ 2698.73. Funding Procedure.

(a) Funding of a grant shall be in the form of a grant award agreement. Each applicant whose application has been approved for grant funding shall submit an enabling resolution by the county Board of Supervisors approving and authorizing execution of a grant award agreement.

(b) Distribution of grant award funds shall be on a quarterly basis. Funding and dates of distribution shall be contingent upon the adoption of an annual State Budget Act and the collection of assessments. Funds to be distributed for the California Highway Patrol shall be deposited in the motor vehicle account.

(c) Within 60 days after the end of each funding cycle, a grantee shall provide the Department with an estimate of any unexpended and/or unencumbered funds.

(d) A grantee who has undertaken investigations and prosecutions which will carry-over into a subsequent funding cycle may carry-over into the subsequent funding cycle distributed but unused funds not exceeding twenty-five percent (25%) of the total funding cycle, provided that the grantee files a written plan, at the end of the funding cycle, which specifies and justifies to the Commissioner how those funds will be used. In the event that, due to extenuating circumstances, distributed funds exceeding twenty-five percent (25%) of the previous total funding cycle are unused, the Commissioner may consider and approve requests for carry-over of the unused funds to the extent that the grantee provides justification.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Sections 1872.8(b)(1), 1874.8 and 1874.81, Insurance Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).
3. Repealer and new subsection (d) filed 4–16–2002 as an emergency; operative 4–16–2002 (Register 2002, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–14–2002 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 4–16–2002 order transmitted to OAL 7–24–2002 and filed 8–28–2002 (Register 2002, No. 35).

§ 2698.74. Strategic Plan.

A strategic plan shall include the following elements:

(a) Table of Contents.

(b) Problem Statement: Each application shall include for the applicable county:

(1) A narrative description of the organized automobile insurance fraud activity in the county, including any supporting data, evidence, or indicators of fraudulent related activity.

(2) A description of the general criminal activity, based upon the most recent California Crime Index Annual Report by the California Attorney General.

(3) Population density, based upon the most recent annual report compiled by the California Department of Finance, Demographic Research Unit.

(4) Automobile insurance claims frequency.

(5) Number of automobile fraud suspected fraudulent claims reported to the Division during a 36–month period immediately preceding the submission of the application.

(6) Evidence of prior and current organized automobile insurance fraud activity.

(c) Qualifications: A description of the applicant's experience in prosecuting automobile insurance fraud which for the purpose of this section shall include economic auto theft cases, for a three–year period preceding the application. The applicant shall include in this section:

(1) The number of automobile insurance fraud investigations initiated and/or coordinated with the Fraud Division, California Highway Patrol and other law enforcement agencies.

(2) The number of automobile insurance fraud related complaints and/or indictments.

(3) The number of automobile insurance fraud related arrests and convictions.

(4) A statement of the amount of charged fraud from the investigations and prosecutions identified in item (1)–(3).

(5) The complexity of the investigations and prosecutions, including the number of claims directly related to such automobile insurance fraud investigation and prosecution.

(d) Program Strategy: A statement of program strategy shall include:

(1) Outreach: Descriptions of the manner in which the grantee will develop its caseload referrals, whether directly from the Fraud Division, California Highway Patrol and from other law enforcement agencies and/or insurers.

(2) The number and ratio of the applicant's investigators to attorney to be funded by the grant award which reflect the most effective use of those resources under a coordinated investigation and prosecution program.

(3) List of personnel, by position title and function, that will be funded in full or in part through a grant award, including descriptions of the qualifications of personnel to be assigned to the program and an organization chart identifying those positions.

(e) Program Coordination: A description of the manner in which each grantee plans to coordinate its efforts and work with the Fraud Division, the California Highway Patrol and other participating agencies and interested insurers.

(f) Management Plan: A detailed plan and schedule of the steps the grantee will complete in achieving the objectives of the program and a discussion of how the program staff will be organized and what internal quality control and budget monitoring procedures will be employed. This part shall also include how this program will be integrated with any other anti–fraud program(s) maintained within the grantee's office.

(g) Staff development: The plan for ongoing training of personnel in the prosecution of organized automobile insurance fraud. Staff development may be addressed through coordination with the Fraud Division, insurers, or other entities.

(h) Objectives: An outline of the applicant's program goals for each funding cycle of the grant period. Applicants must state how these goals will be achieved in coordination with the Fraud Division, the California Highway Patrol and other law enforcement agencies.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Sections 1874.8(b) and (c) and 1874.81(a)(3) and (5), Insurance Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).

§ 2698.75. Budget Proposal.

(a) A proposed budget shall be presented in line–item detail and cover each funding cycle. The applicant's proposed budget shall include the following estimates:

(1) Salaries and benefits computed at the county salary and benefit schedule. A current copy of the pertinent schedule shall be submitted with the proposed budget.

(2) Support costs.

(b) Each applicant shall use the following guidelines in preparing its proposed budget:

(1) Itemized costs shall conform to applicant's policy regarding appropriateness of expenses.

(2) Allowable costs are those direct and indirect operating costs incurred in the support of program activities, including program related travel, equipment costs proportional to program–related use of the equipment, facilities cost, expert witness fees and audits.

(3) Non–allowable costs include:

(A) Real property purchases and improvements.

(B) Aircraft or motor vehicles except the purchase of motor vehicles specifically justified to and approved in advance by the Commissioner.

(C) Interest payments.

(D) Food and beverages, except as purchased in connection with program–related travel. Food and beverages costs shall not exceed the applicant's per diem schedule.

(E) Weapons or ammunition unless included as part of a benefit package.

(c) Indirect costs: Indirect costs are those not capable of being assigned to a particular project or program, but necessary to the operation of the organization and the performance of the program. The costs of operating and maintaining facilities, accounting services, and administrative salaries are examples of indirect costs. Indirect costs shall not exceed 10 percent of personnel salaries (excluding benefits and overtime) or 5 percent of total direct program costs (excluding equipment).

(d) Program funds of grantees may only be used to support the grantee's activity in the investigation, prosecution of organized automobile fraud activity.

(e) Budget modifications must be pre–approved in writing by the Commissioner.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Sections 1872.8(b)(1), 1874.8 and 1874.81(a)(2) and (5), Insurance Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).

§ 2698.76. Determination and Criteria for Awarding of Grants.

(a) In determining to award a grant under this program, the Commissioner shall consider the information provided in an application and may consider the recommendations and advice of the Fraud Division and the Commissioner of the Highway Patrol.

(b) Priority shall be given to those grant applications which, in the determination of the Commissioner, have the potential to have the greatest impact on organized automobile insurance fraud activity.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Sections 1872.8(b)(1), 1874.8(b) and (c) and 1874.81(a), Insurance Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).

§ 2698.77. Grant Reporting and Audit.

(a) Each grantee shall submit annual reports to the Commissioner covering the preceding funding cycle. The reports shall consist of:

(1) An expenditure report, which shall include:

(A) All operation costs.

(B) Personnel: salaries and benefits.

(C) Explanation of any material variances from the proposed budget and strategic plan submitted with the grant application.

(2) A financial audit report prepared by an independent, qualified state or local government auditor or independent public accountant licensed by the State of California or the county auditor controller. The audit report shall certify that local expenditures were in conformance with the purposes of the program as specified in Section 1874.8 of the Insurance Code, these regulations, and the application for grant funding as approved by the grant award agreement.

(A) The auditor shall use county policies and procedures as the standard for verifying appropriateness of personnel and support costs.

(B) In the event that the program audit is included as part of an organization–wide audit, revenues and expenditures for the local program must be shown separately.

(3) A program report which shall identify and discuss the following items as they relate to the program:

(A) The number of investigations initiated and/or coordinated with the Fraud Division, California Highway Patrol and other law enforcement agencies.

(B) The number of arrests.

(C) The number of prosecutions.

(D) The number of convictions.

(E) The charged fraud and dollar savings realized as a result of reported prosecutions.

(F) The goals and objectives achieved by the grantees as set forth in the strategic plan including an explanation of any goal not achieved as identified in the strategic plan.

(G) A summary of the other activities directed toward the reduction of organized automobile insurance fraud activity in coordination with all interested insurers and other participating agencies.

(b) The annual reports shall be submitted to the Commissioner no later than two (2) months after the close of the grant funding cycle as specified in the application. A county may request, in writing, a single limited extension to a date certain for submission of the annual reports, in the event an organization–wide audit would delay submission of the required report(s).

(c) There shall be a grant liquidation period of sixty (60) days following the termination of the grant period during which costs incurred but not paid may be paid and deducted from the program budget.

(d) Except as provided in this section, financial audits under this program shall be performed in accordance with the standards set forth in the Government Accounting Standards Revised (July 1999) published by the Comptroller General of the United States, General Accounting Office. The above General Accounting Standards Revised (1999) are incorporated herein by this reference.

(e) The Commissioner shall perform the following audits and reviews:

(1) Fiscal audit of each grant program at least once every three years.

(2) An annual review of the grantee performance under the program

(3) Any additional audits or reviews of a grantee's program as are necessary for the effective and efficient administration of the program.

(f) The grantee shall cooperate with the Commissioner in the performance of the audits and reviews. The grantee shall provide access to all documents related to the program and fiscal operation of the grant program as deemed necessary by the Commissioner. Refusal to cooperate with the Commissioner under this subsection may constitute good cause for redistribution of the grant funding.

NOTE: Authority cited: Sections 1874.8 and 1874.81, Insurance Code. Reference: Sections 1872.8(b)(1), 1874.8(b) and (d) and 1874.81, Insurance Code.

HISTORY

1. New section filed 7–7–2000 as an emergency; operative 7–7–2000 (Register 2000, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–7–2000 order, including amendment of subsection (f), transmitted to OAL 10–12–2000 and filed 11–21–2000 (Register 2000, No. 47).

Article 6. Law Enforcement Access to Insurance Claims Information

§ 2698.80. Definitions.

(a) "Claims Analysis Bureau" (CAB) means a licensed, non–profit corporation, organized for the purpose of fraud prevention or is a corporation that has made the filings required by Section 1855.2 that receives, compiles and transmits insurance claims information pursuant to California Insurance Code (CIC) Sections 1875. 14.

(b) "Commissioner" means the Commissioner of the Department of Insurance of the State of California.

(c) "Department" means the Department of Insurance of the State of California.

(d) "Fraud Division" means the Department of Insurance of the State of California Fraud Division, formerly known as the Bureau of Fraudulent Claims.

(e) "Insurance claims information" means any bodily injury, medical payment or uninsured motorist claim made under a policy of automobile insurance.

(f) "Insurer" shall have the same meaning as is given by CIC Section 1874.1.

(g) "Law Enforcement" shall have the same meaning as is given by Penal Code Section 830.1, 830.32, 830.3, 830.8, 830.37 and 830.39 and shall also include investigators for the Department of Consumer Affairs Bureau of Automotive Repair.

(h) "Match Report" or "Matched Claims Data Format" means the manner in which data is provided to insurers by the Claims Analysis Bureau as a result of a match between insurance claims information submitted by one insurer and information previously submitted by another insurer.

(i) "Supplemental Information" means any insurance claims information provided to the insurer after the initial insurance claims information is filed.

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Section 1875.18, Insurance Code.

HISTORY

1. New article 6 (sections 2698.80–2698.86) and section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).
2. Repealer of article 6 (sections 2698.80–2698.86) and section and new article 6 (sections 2698.80–2698.89.1) and section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.81. Prior Approval of Plan of Operation for Claims Analysis Bureau.

(a) Every CAB shall obtain the prior approval of a plan of operation as a CAB from the Insurance Commissioner before it may perform any of the functions described in California Insurance Code Section 1875.11.

(b) Every plan of operation as a CAB submitted to the Insurance Commissioner for approval pursuant to Section 2698.81 shall:

(1) set forth written procedures and physical controls to: prevent the unauthorized access to its system of records, to prevent unauthorized disclosure of records and to prevent physical damage to or destruction of records. At a minimum the administrative policies and procedures and

physical controls shall fully comply with the requirements set forth at Section 2698.87(a) (1)–(5);

(2) set forth written procedures regarding the use of subcontractors to perform any function described in CIC 1875.11 (b). At a minimum, such administrative policies and procedures and physical controls shall fully comply with the requirements set forth at Section 2698.87(c) (1)–(2).

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Section, 1875.18(d), Insurance Code.

HISTORY

1. New section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).

2. Repealer and new section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.82. Deposit of Information to Claims Analysis Bureaus.

(a) Insurers shall deposit insurance claims information to a licensed insurance CAB within sixty (60) calendar days of receipt of that insurance claims information.

(b) Any supplemental insurance claims information provided to the insurer during the life of the claim shall be reported within sixty (60) calendar days of receipt of that supplemental insurance claims information.

(c) No Claims Analysis Bureau shall charge any fee to any insurer for depositing the information required by this section including supplemental insurance claim information.

(d) The Commissioner reserves the right to perform such audits as he or she may deem necessary to determine that appropriate insurance claims information is deposited within the time frames specified in these regulations.

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Section 1875.18, Insurance Code.

HISTORY

1. New section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).
2. Repealer and new section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

3. Amendment of subsection (b) and NOTE filed 12–19–2007; operative 1–18–2008 (Register 2007, No. 51).

§ 2698.83. Law Enforcement Access to Claims Analysis Bureau Insurance Claims Information.

(a) Access to insurance claims information shall be made available to law enforcement solely for the purpose of detection and investigation of insurance fraud.

(b) No claims analysis bureau shall charge any fee to any law enforcement agency for access to any insurance claims information as defined in these regulations.

(c) A claims analysis bureau shall provide insurance claims information in the form match report to law enforcement entities within 10 calendar days of receipt of a complete and properly executed written request for information.

(d) A written request by law enforcement entities for insurance claims information shall contain the following information:

(1) the specific insurance claims information requested; and

(2) the identity of the requesting party including contact information.

(e) If a claims analysis bureau receives a written request for information from a law enforcement agency that does not comply with the provisions of 2698.83 (d) (1)–(2) the Claims Analysis Bureau shall specify the manner or non–compliance and return the request to the law enforcement agency for correction amendment and re–submittal.

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Section 1875.18, Insurance Code.

HISTORY

1. New section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).

2. Repealer and new section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.84. Procedure for Correction of Incorrect Information Deposited In a Claims Analysis Bureau.

(a) Any person who believes that any insurance claims information maintained by a Claims Analysis Bureau is incorrect may request in writing that the CAB investigate whether or not the information is correct.

(b) Within 30 days from the date of receipt of a written request pursuant to subsection 2698.84(a), a CAB shall either:

(1) Correct, amend or delete the portion of the insurance claims information in dispute; or

(2) Notify the individual of:

(A) The CAB's refusal to make such correction, amendment or deletion.

(B) The reasons for the refusal.

(C) The individual's right to file a statement as provided in subdivision (d).

(c) If the CAB corrects, amends or deletes recorded insurance claims information in accordance with this subsection, the CAB shall notify the individual in writing and furnish the correction, amendment or fact of deletion to any person specifically designated by the individual who may have, within the preceding two years, received the incorrect information.

(d) Whenever an individual disagrees with a CAB's refusal to correct, amend or delete insurance claims information, the individual shall be permitted to file with the CAB:

(1) A concise statement setting forth what the individual asserts is the correct, insurance claims information; and

(2) A concise statement of the reasons why the individual disagrees with the insurance claims information maintained by the CAB.

(e) In the event an individual files either statement as described in subdivision (d), the CAB shall file the statement with the disputed insurance claims information and provide a means by which anyone reviewing the disputed insurance claims information will be made aware of the individual's statement and have access to it.

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Section 1875.18(d)(2), Insurance Code.

HISTORY

1. New section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).
2. Repealer and new section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.85. Examination by the Insurance Commissioner of Insurance Claims Information Transmitted to Claims Analysis Bureau.

(a) The Commissioner may perform an examination of any insurance claims information transmitted to any CAB he or she may deem necessary and shall have access to all non–privileged reports, working papers, correspondence, or other documents, including audit reports and audit working papers relating to the insurer's receipt, compilation and transmission of insurance claims information.

(b) The expenses of any examination of insurance claims information conducted pursuant to subsection 2698.85 (a) shall be borne by the organization that is the subject of the examination.

NOTE: Authority cited, 1875.18(d)(2), Insurance Code. Reference: Sections 736 and 1875.18, Insurance Code.

HISTORY

1. New section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).
2. Repealer and new section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.86. Public Records Act Requests and Subpoenas Seeking Insurance Claims Information from Claims Analysis Bureaus.

(a) A Claims Analysis Bureau shall not release any insurance claims information in response to a Public Records Act Request.

(b) A Claims Analysis Bureau shall not release any insurance claims information received pursuant to the provisions of California Insurance Code 1875.18 to public inspection until such time as the release of the information is required in connection with a criminal or civil proceeding.

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Sections 1875.16 and 1875.18, Insurance Code.

HISTORY

1. New section filed 5–19–97; operative 6–18–97 (Register 97, No. 21).
2. Repealer and new section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.87. Security Procedures Applicable To Information Deposited To A Claims Analysis Bureau.

(a) Every CAB shall establish and adopt administrative policies and procedures and physical controls to: prevent the unauthorized access to its system of records; to prevent unauthorized disclosure of records; and to prevent physical damage to or destruction of records. At a minimum the administrative policies and procedures and physical controls shall require that:

(1) records are protected from public view;

(2) the area in which records are kept is supervised during business hours to prevent unauthorized persons from having access to them;

(3) records are inaccessible to unauthorized persons outside of business hours;

(4) records are not disclosed to unauthorized persons or under unauthorized circumstances in either oral or written form; and,

(5) direct access to records is restricted to only those individuals who must have direct access to records in order to perform their duties.

(b) Every Claims Analysis Bureau shall provide annual training regarding its administrative policies and procedures and physical controls to all employees to prevent: unauthorized access to its system of records; unauthorized disclosure of records; and physical damage to or destruction of records.

(c) A CAB may delegate any functions described in CIC 1875.11 (b) to another entity providing:

(1) the CAB provides annual training and instruction required by subsection 2698.87 (b) to all individuals performing any aspect of the function delegated by the CAB; and,

(2) the CAB annually provides to the Insurance Commissioner a list of the names, addresses and the Taxpayer Identification Number (TIN) of the individuals that perform any aspect of the function delegated by the CAB to the entity.

(d) Every Claims Analysis Bureau shall maintain records establishing full compliance with the applicable provisions of Section 2698.87 and shall immediately provide any requested information regarding information deposited with the CAB to the Insurance Commissioner upon request.

NOTE: Authority cited: Section 1875.18(d)(2), Insurance Code. Reference: Section 1875.18, Insurance Code

HISTORY

1. New section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).
2. Amendment of NOTE filed 12–19–2007; operative 1–18–2008 (Register 2007, No. 51).

§ 2698.88. Immunity From Defamation, Invasion of Privacy or Negligence.

(a) A Claims Analysis Bureau or any person employed therein that provides insurance claims information to any other person or entity pursuant to California Insurance Code Section 1875.18 shall have the same immunity provided under California Insurance Code Section 791.21 to any person that discloses personal or privileged information; however, this subsection does not provide immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

NOTE: Authority cited: Sections 1875.18(d)(2), Insurance Code. Reference: Section 1875.18(c)(2) and (d)(2), Insurance Code.

HISTORY

1. New section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.89. Penalties.

(a) The Commissioner may suspend or revoke the license of any CAB if the CAB fails to comply with any provisions of this subchapter.

(b) The Commissioner shall conduct any proceeding to suspend or revoke any license granted to a CAB in accordance with the Administrative Procedures Act, Chapter 5(commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Penalties for noncompliance are cumulative and shall be in addition to any other penalties or remedies provided by the Insurance Code.

NOTE: Authority cited: Section 1875.18, Insurance Code. Reference: Sections 1875.18, 12921 and 12926, Insurance Code.

HISTORY

1. New section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).

§ 2698.89.1. Effective Date.

(a) The regulations set forth in this subchapter shall become effective upon filing with the Secretary of State.

(b) All persons or entities subject to the regulations set forth in this subchapter shall have until July 1, 2007 to fully comply with the provisions of this subchapter.

NOTE: Authority cited: Section 1875.18, Insurance Code. Reference: Section 1875.18, Insurance Code

HISTORY

1. New section filed 12–26–2006; operative 1–25–2006 (Register 2006, No. 52).
2. Amendment of NOTE filed 12–19–2007; operative 1–18–2008 (Register 2007, No. 51).

[The next page is 752.19.]

Article 7. Direct Repair Programs and Auto Body Repair Labor Rate Surveys

§ 2698.90. Direct Repair Programs.

(a) As used in this Article, a "Direct Repair Program" includes any program under which an insurer refers, suggests, or recommends an auto body repair facility to insureds or claimants and the insurer has a formal agreement, whether written or otherwise, with the repair facility to provide auto body repair services to such insureds or claimants.

(b) Auto body repair shops reporting a denial to participate in an insurer's Direct Repair Program pursuant to Insurance Code section 758 shall make such reports to the Market Conduct Division/Field Claims Bureau of the Department of Insurance.

NOTE: Authority cited: Sections 758, 12921 and 12926, Insurance Code. Reference: Section 758, Insurance Code.

HISTORY

1. New article 7 (sections 2698.90–2698.91) and section filed 9–25–2002; operative 10–25–2002 (Register 2002, No. 39).

§ 2698.91. Auto Body Repair Labor Rate Surveys.

(a) An "auto body repair labor rate survey" is any gathering of information from auto body repair shops regarding what auto body repair labor rate the repair shops charge to determine and set a specified prevailing auto body repair rate in a specific geographic area.

(b) "Prevailing auto body rate" means the rate determined and set by an insurer as a result of conducting an auto body labor rate survey of auto body repair shops in a particular geographic area and used by the insurer as a basis for determining the cost to settle automobile collision, physical damage, and liability claims for auto body repairs.

(c) Any labor rate survey results reported to the Department of Insurance pursuant to Insurance Code section 758 shall include the following:

(1) The name of each auto body repair shop surveyed in the labor rate survey;

(2) The address of each auto body repair shop surveyed in the labor rate survey;

(3) The total number of shops surveyed in the labor rate survey;

(4) The prevailing rate established by the insurer for each geographic area surveyed;

(5) A description of the specific geographic area covered by the prevailing labor rate reported.

(6) A description of the formula or method the insurer used to calculate or determine the specific prevailing auto body rate reported for each specific geographic area.

Any confidential information not required by this section should be removed from the labor rate survey results prior to submitting the survey to the Department of Insurance.

(d) Insurers shall send the results of their labor rate survey to the Market Conduct Division of the Department of Insurance.

(e) The Department of Insurance will make the reports available upon written request to the Custodian of Record pursuant to the Public Records Act.

NOTE: Authority cited: Sections 758, 12921 and 12926, Insurance Code. Reference: Section 758, Insurance Code; sections 6250–6276.48, Government Code.

HISTORY

1. New section filed 9–25–2002; operative 10–25–2002 (Register 2002, No. 39).

Article 8. Disability Insurance Fraud Assessment Grant Program

§ 2698.95. Annual Fee.

(a) Each admitted disability insurer, as provided for by Insurance Code section 1872.85, shall pay an annual fee of ten cents ($.10) for each insured person that is covered by an individual or group disability insurance policy issued in this state during each calendar year or any part thereof. Such assessment shall also be paid by any other entity, doing business in this state, which is liable for any loss due to health insurance fraud.

(b) For purposes of group disability insurance policies, an insured person shall be deemed to include any person that is issued an individual certificate of coverage.

(c) Insurers shall report to the Commissioner by December 31 of each calendar year on the number of insured persons that are covered by an individual or group disability policy.

(d) The annual fee shall be payable upon presentation of an invoice by the Commissioner. Payment of the annual fee shall be considered delinquent if not paid by the insurer within forty–five (45) days of the invoice date and any amount not paid within this period shall be charged a late fee in accordance with Insurance Code section 12995.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805, 824. Reference: Sections 1872.85 and 12995, Insurance Code.

HISTORY

1. New article 8 (section 2698.95) and section filed 8–31–2004; operative 8–31–2004 pursuant to Government Code section 11343.4 (Register 2004, No. 36).
2. Amendment of article heading, new subsection (b), subsection relettering and amendment of NOTE filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.95.1. Authority and Purpose.

These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of Insurance Code section 1872.85. The purpose of these regulations is to set forth the intended and allowable use of funds to be distributed to district attorneys for purposes of enhanced investigation and prosecution of disability insurance fraud cases, including an application process and subsequent reporting requirements.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.95.11. Determination and Criteria for Award of Grants.

(a) Pursuant to Insurance Code section 1872.85(b) and (c), the Commissioner shall distribute funds under this program to district attorneys who are able to show a likely positive outcome that will enhance the prosecution of disability insurance fraud in their jurisdiction. In order to obtain funds under this program, a district attorney must submit an application pursuant to Insurance Code section 1872.85(b).

(b) In determining to award a grant under this program, the Commissioner shall consider the information provided in an application and may consider the recommendations and advice of the Fraud Division.

(c) Priority shall be given to those grant applications which, in the determination of the Commissioner, have the potential to have the greatest impact on disability insurance fraud activity.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.95.12. Definitions.

For the purposes of these regulations:

(a) "Application" means the written document submitted to the Commissioner by which a local district attorney requests program funding, including a plan setting forth the district attorney's intended use of funds to enhance investigation and prosecution of disability insurance fraud.

(b) "Assessment" means the surcharge collected from insurers and self–insured employers to support the program to enhance investigation and prosecution of disability insurance fraud.

(c) "Case" means the file set up by the California Department of Insurance Fraud Division (formerly, the Bureau of Fraudulent Claims), and/or district attorney in the course of and for the purpose of investigation, de-

velopment of evidence and prosecution of individual or consolidated activities of suspected disability insurance fraud.

(d) "Claim" means the request for payment of disability benefits which has been submitted to an insurer.

(e) "Commissioner" means the Insurance Commissioner of the state of California.

(f) "County Plan" means the plan submitted to the Commissioner as part of the application process by the local district attorney which details the projected use of the funds sought pursuant to these regulations.

(g) "Department" means the California Department of Insurance.

(h) "District Attorney" means the prosecuting officer of a California county jurisdictional district.

(i) "Fraud Division" or "Division" means the California Department of Insurance Fraud Division, formerly known as the Bureau of Fraudulent Claims. The former Bureau was designated a Division subsequent to the original enactment of section 1872.85 of the Insurance Code.

(j) "Funding cycle" means a period of one fiscal year.

(k) "Grantee" means a grant–funded applicant.

(*l*) "Incidental Expenses", as used in Insurance Code section 1872.85(a), means those costs incurred by the California Department of Insurance to administer the program and may include reasonable costs for collection of assessments, administrative support of the Fraud Division program component, and management of the distribution and oversight of monies allocated to the district attorneys.

(m) "Program" means those activities conducted by the Department, or any other agency, which are directed toward the enhanced investigation and prosecution of disability insurance fraud and which require funding or administration through assessments and the distribution of funds to the Fraud Division and to district attorneys.

(n) "Insurer" shall have the same meaning as used in Insurance Code section 23.

(o) "Regulations" means these regulations, California Code of Regulations Title 10, Chapter 5, Subchapter 9, Article 8.

(p) "Suspected Fraudulent Claim" means a claim which has been referred to the Division because the insurer reasonably believes that the claim involves a person who has committed a fraudulent act related to disability insurance.

NOTE: Authority cited: Section 1872.85, Insurance Code; *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.96. Application Procedure and Contents.

(a) A Request for Application (RFA) shall be distributed annually to each county district attorney in the state. The Commissioner shall designate a date for the submission of an application requesting grant funding under this program. Notice of the date for submission shall be mailed to each district attorney at least 30 days before the date set for submission of an application. Applications received after the date set for submission will not be considered for funding.

(b) An application shall include:

(1) a "county plan" as more specifically described in section 2698.97.1.

(2) a "budget proposal" as more specifically described in section 2698.98.

(3) a list of program contacts for the applicant that shall include the name, position, business address, telephone, email address and fax number for each individual.

(c) In addition to an application, each applicant shall submit as a separate document a memorandum of understanding, which sets forth the commitments of the grantee and the Division under the program.

(d) A joint application addressing a multi–county area may be submitted. Joint applications and accompanying documents as provided in subsection (a) shall, in addition to the items specified in subsection (b) of this section, address the use of funds by and between each participating county and designate a lead county for the purpose of receipt and distribution of the grant funding and to serve as the responsible entity for the administration of the grant.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.97. Funding Procedure.

(a) Funding of a grant shall be in the form of a grant award agreement. Each applicant whose application has been approved for grant funding shall submit an enabling resolution by the county Board of Supervisors approving and authorizing execution of a grant award agreement.

(b) Distribution of grant award funds shall be on a quarterly basis. Funding and dates of distribution shall be contingent upon the adoption of an annual State Budget Act and the collection of assessments. The duration of a grant, otherwise known as a funding cycle, shall be one fiscal year.

(c) Within 60 days after the end of each funding cycle, a grantee shall provide the Department with an estimate of any unexpended and/or unencumbered funds. A grantee who has undertaken investigations and prosecutions which will carry–over into a subsequent funding cycle may carry–over into the subsequent funding cycle distributed but unused funds not exceeding twenty–five percent (25%) of the total funding award, provided that the grantee files a written plan, at the end of the funding cycle, which specifies and justifies to the Commissioner how those funds will be used. In the event that, due to extenuating circumstances, distributed funds exceeding twenty–five percent (25%) of the previous total funding award are unused, the Commissioner may consider and approve requests for carry–over of the unused funds to the extent that the grantee provides justification.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.97.1. County Plan.

A county plan shall include the following elements:

(a) Problem Statement: A description of the disability insurance fraud problem in the county, including how it arose, why it is important, its unique aspects, if any, and what is needed to resolve the problem, including supporting data, evidence, or indicators of fraudulent activity related to disability insurance.

(b) Supporting data may include the following items:

(1) A narrative description of the disability insurance fraud activity in the county, including any supporting data, evidence or indicators of fraudulent related activity.

(2) A description of the general criminal activity, based upon the most recent California Crime Index Annual Report by the California Attorney General.

(3) Population density, based upon the most recent report compiled by the California Department of Finance, Demographic Research Unit.

(4) Disability insurance claims frequency.

(5) Number of disability fraud suspected fraudulent claims reported to the Division during a 36–month period immediately preceding the submission of the application.

(6) Evidence of prior and current disability insurance fraud activity.

(c) Qualifications: A description of the applicant's experience in investigating disability insurance fraud including:

(1) The total amount expended to support the district attorney's investigation and prosecution of disability insurance fraud, including the details of the following items:

(A) Personnel costs including salaries and benefits.

(B) Operations expenses, including space, equipment, travel and other expenses in support of the program.

(2) For applications submitted after fiscal year 2005–2006, the following factors shall be included in the County Plan:

(A) The total amount of funds received from the Disability Insurance Fraud Program by the local district attorney in previous years and a copy of the most recent annual report.

(B) The results obtained through implementation of the program, including:

1. The number of investigations initiated or coordinated with other law enforcement agencies.

2. The number of arrests or convictions.

3. The number of indictments or complaints.

4. A comparison of the amounts originally claimed in cases determined to be fraudulent compared to payments actually made.

(d) Program Strategy:

(1) Outreach. A description of the manner in which the district attorney will develop his or her caseload, the source(s) for referrals for cases for investigation or prosecution, whether directly from the Fraud Division or from other law enforcement agencies and/or insurers.

(2) Personnel. Justification for the number of personnel, position titles and position justification for personnel which will be funded fully or in part through grant funds, including descriptions of the qualifications of personnel to be assigned to the program and an organization chart identifying positions to be funded.

(3) Program Coordination. A description of the manner in which the district attorney plans to coordinate involved sectors, including insurers, medical and legal provider communities, the Division, and local law enforcement agencies.

(4) Management Plan. A detailed plan and schedule of the steps the district attorney will complete in achieving the objectives of the program and a discussion of how the program staff will be organized and what internal quality control and budget monitoring procedures will be employed. This part shall also include how this program will be integrated with any other anti–fraud program(s) maintained within the district attorney's office.

(5) Staff Development. The plan for ongoing training of personnel on the investigation and prosecution of disability insurance fraud. Staff development may be addressed through coordination with the Division, insurers, or other entities.

(6) Objectives. This section shall outline the district attorney's anticipated achievements in the following areas:

(A) Estimated number of investigations to be initiated during the funding cycle, including separate estimate of the number resulting from carryover investigations; and

(B) Estimated number of prosecutions to be initiated during the funding cycle.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.98. Budget Proposal.

The proposed budget forms the basis for program management and audit and must be presented in line–item detail and cover a one year program period from July through June of each fiscal year. Annual budget levels shall be included in the Request for Application (RFA). The budget may include a line item for an independent audit to be completed at the end of each annual program period or as specified in the RFA. The district attorney's budget shall include the following:

(a) Salaries and benefits computed at the county salary and benefit schedule. A current copy of the pertinent schedule shall be submitted with the proposed budget.

(b) Operation support costs.

(1) Estimated costs shall be listed by line item.

(2) Itemized costs shall conform to county policy regarding appropriateness of expenses.

(3) Allowable costs are those costs incurred in direct support of local program activities, including program related travel, equipment costs proportional to program–related use of the equipment, facilities cost, expert witness fees and audits.

(c) Indirect costs are those not capable of being assigned to a particular project or program, but necessary to the operation of the organization and the performance of the program. The costs of operating and maintaining facilities, accounting services, and administrative salaries are examples of indirect costs. Indirect costs shall not exceed 10 percent of personnel salaries (excluding benefits and overtime) or 5 percent of total direct program costs (excluding equipment).

(d) Non–allowable budget items include:

(1) Real property purchases and improvements.

(2) Aircraft or motor vehicles, except the purchase of motor vehicles which is specifically justified to the Commissioner.

(3) Interest payments.

(4) Food and beverages, except as purchased in connection with program–related travel. Food and beverages costs shall not exceed the applicant's per diem schedule.

(5) Weapons or ammunition unless included as part of a benefit package.

(e) Program funds must be used to support enhanced investigation and prosecution of disability insurance fraud and cannot be used to supplant funds which in the absence of program funds would be made available for any portion of the local disability insurance program.

(f) Budget modifications are allowable so long as they do not change the grant award amount.

(g) The annual and proposed use of these funds are subject to full public disclosure.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11–3–2005; operative 12–3–2005 (Register 2005, No. 44).

§ 2698.98.1. District Attorney Reporting and Commissioner's Audit.

Each district attorney receiving funds pursuant to Insurance Code section 1872.85 shall submit an annual report to the Commissioner regarding the local program and its accomplishments. Failure to submit the annual report shall affect subsequent funding decisions. The report shall include the following items:

(a) An Expenditure Report, which shall include information for the following:

(1) Personnel: salaries and benefits.

(2) Operations costs breakdown.

(3) Explanation of any significant variances from the county's application as approved.

(b) A financial Audit Report prepared by an independent, qualified state or local government auditor or independent public accountant licensed by the State of California or the county Auditor Controller. The Audit Report shall reflect that local expenditures were made for the purposes of the program as specified in section 1872.85 of the Insurance Code, these Regulations, the guidelines in the Request for Application and the county's application.

(1) The auditor shall use county policies and procedures as the standard for verifying appropriateness of personnel and support costs.

(2) In the event that the program audit is included as part of an organization–wide audit, revenues and expenditures for the local program must be shown separately.

(c) Except as provided in this section, financial audits under this program shall be performed in accordance with the standards set forth in Government Auditing Standards (Revised June 2003) published by the Comptroller General of the United States, General Accounting Office. The above Government Auditing Standards (Revised June 2003) are incorporated herein by this reference.

(d) A Program Report which shall include the following:

(1) The number of investigations initiated related to disability insurance fraud.

(2) The number of arrests related to disability insurance fraud.

(3) The number of prosecutions related to disability insurance fraud.

(4) The number of convictions related to disability insurance fraud.

(5) The dollar savings realized as a result of disability insurance fraud case prosecutions.

(6) A summary of the activity directed toward the reduction of disability insurance fraud with the following:

(A) Fraud Division.

(B) Insurance companies.

(e) The deadlines for submissions are as follows:

(1) Expenditure Reports and Audit Reports must be submitted to the Commissioner no later than four (4) months after the close of the funding cycle as specified in the Request for Application. A county may request an extension in the event an organization-wide audit will delay submission of the audit.

(2) Program Reports must be submitted to the Commissioner no later than (2) months after the close of the funding cycle as specified in the Request for Application.

(f) There shall be a grant liquidation period of ninety (90) days following the termination of the funding cycle during which costs incurred but not paid may be paid and deducted from the program budget.

(g) The Commissioner may perform such additional audits or reviews of any local programs as he or she may deem necessary and shall have access to all working papers, correspondence, or other documents, including audit reports and audit working papers related to the audit report or local program.

(h) Notwithstanding any other provision of the law, the Commissioner shall perform a fiscal audit of the program administered under this section once every three years.

NOTE: Authority cited: Section 1872.85, Insurance Code; and *CalFarm Insurance Company, et al. v. Deukmejian, et al.* (1989) 48 Cal.3d 805 and 824. Reference: Section 1872.85, Insurance Code.

HISTORY

1. New section filed 11-3-2005; operative 12-3-2005 (Register 2005, No. 44).

Subchapter 10. Conservation and Liquidation Office

Article 1. Conservation and Liquidation Office

§ 2698.99. Conflict of Interest Code for the Conservation and Liquidation Office.

Insurance Code Section 1035.2 requires the California Department of Insurance ("CDI") to promulgate and adopt a Conflict of Interest Code pursuant to the provisions of Article 3 (commencing with Section 87300) of Chapter 7 of Title 9 of the Government Code pertaining to the officers and employees of the CDI's Conservation & Liquidation Office. The Fair Political Practices Commission ("FPPC") has adopted a regulation (Title 2 California Code of Regulations Section 18730) containing the terms of a standard Conflict of Interest Code which may be incorporated by reference in an agency's code. After public notice and hearing, it may be amended by the FPPC to conform to amendments in the Political Reform Act (Government Code Sections 81000, *et seq.*). Therefore, the terms of Title 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the FPPC are hereby incorporated by reference. This regulation together with the attached Appendix designating officers and employees and establishing disclosure categories shall constitute the Conflict of Interest Code of the CDI's Conservation & Liquidation Office.

Designated employees shall file their statements with the Department of Insurance's Conservation and Liquidation Office who will make the statements available for public inspection. (Gov. Code Section 81008.) Upon receipt of the statement for the Chief Executive Officer, the agency shall make and retain a copy and forward the original to the Fair Political Practices Commission. Statements for all other designated employees will be retained by the agency.

Appendix—Designated Employees

Designated Employees	*Disclosure Category*
Chief Executive Officer	1
Internal Auditor	1
Chief Operations Officer	1
Chief Financial Officer	1
Chief Reinsurance Officer	1
Chief Estate Trust Officer	1
Assistant Vice-President of Claims	1
Vice-President of Finance	1
Estate Trust Officer	1
All Consultants*	1
Estate Reinsurance Manager	1
Claims Manager	1
Network Operations Manager	2
Human Resources Manager	2
Administration Manager	2
Executives of Conserved/Liquidated Insurance Company	Same as CLO counterpart, e.g., CFO of conserved/ liquidated company is in Disclosure Category 1

*With respect to Consultants, the Chief Executive Officer may determine in writing that a particular consultant, although a "designated person," is hired to perform a range of duties that are limited in scope and thus is not required to comply with the disclosure requirements described in this Section. Such determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements shall be retained in the Department of Insurance, Conservation and Liquidation Office's files. Nothing herein excuses any such consultant from any other provision of the Conflict of Interest Code.

Disclosure Categories

Designated employees in Category 1 shall report all interests in real property in the State of California, as well as investments, business positions and sources of income, including gifts, loans and travel payments.

Designated employees in Category 2 shall report all investments, business positions and income, including gifts, loans and travel payments, from sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the designated employee's department or area of authority.

NOTE: Authority cited: Section 87300, Government Code; and Section 1035.2, Insurance Code. Reference: Sections 87300-87302 and 87306, Government Code; and California Code of Regulations, Title 2, Section 18730, et seq.

HISTORY

1. New subchapter 10 (article 1), article 1 (section 2698.99) and section filed 11-4-2002; operative 12-4-2002. Approved by Fair Political Practices Commission 9-17-2002 (Register 2002, No. 45).
2. Amendment of section and Appendix filed 1-23-2006; operative 2-22-2006. Approved by Fair Political Practices Commission 11-4-2005 (Register 2006, No. 4).

Subchapter 11. Governing Procedure for Hearings

Article 1. Governing Procedure for Hearings

§ 2698.99.10. Authority.

NOTE: Authority cited: Sections 11400.20 and 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. New subchapter 11 (article 1), article 1 (sections 2698.99.10-2698.99.13) and section filed 3-20-2003; operative 4-19-2003 (Register 2003, No. 12).
2. Change without regulatory effect renumbering former subchapter 11, article 1 (sections 2698.99.10-2698.99.13) to subchapter 4.5, article 1 (sections 2615-2615.3) and renumbering section 2698.99.10 to section 2615 filed 6-3-2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2698.99.11. Purpose.

NOTE: Authority cited: Section 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. New section filed 3–20–2003; operative 4–19–2003 (Register 2003, No. 12).
2. Change without regulatory effect renumbering section 2698.99.11 to section 2615.1 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23). For prior history of section 2615.1, see Register 96, No. 45.

§ 2698.99.12. Governing Procedure: Requirements.

NOTE: Authority cited: Section 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. New section filed 3–20–2003; operative 4–19–2003 (Register 2003, No. 12).
2. Change without regulatory effect renumbering section 2698.99.12 to section 2615.2 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

§ 2698.99.13. Governing Procedure: Pre–Hearing Order.

NOTE: Authority cited: Section 11415.10, Government Code. Reference: Section 21.5, Insurance Code.

HISTORY

1. New section filed 3–20–2003; operative 4–19–2003 (Register 2003, No. 12).
2. Editorial correction amending internal cross–reference (Register 2003, No. 20).
3. Change without regulatory effect renumbering section 2698.99.13 to section 2615.3 filed 6–3–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 23).

* * *

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 5.5. Major Risk Medical Insurance Board

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Chapter 5.5. Major Risk Medical Insurance Board

Article 1. Definitions

§ 2698.100. Definitions.

For the purpose of this part:

(a) "Appellant" means an applicant, subscriber, enrolled dependent, or dependent subscriber who has filed an appeal with the program.

(b) "Applicant" means an individual who has filed an application for major risk medical coverage with the program.

(c) "Authorized Representative" means any person or entity who has been designated, in writing, by the appellant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) "Certificate of Program Completion" means a certificate issued by the Program to persons leaving the Program after 36 consecutive months of coverage.

(f) "Coverage" means the payment by the program or other health plan or insurer for medically necessary services provided by institutional and professional providers.

(g) "Creditable coverage" means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self–insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement, Medicare supplement, long–term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self–insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere of medical, hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901)(FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104–191.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).

(h) "Day" means calendar day unless specified otherwise.

(i) "Dependent" means:

(1) The spouse of a subscriber or applicant at the time of application.

(2) An unmarried child under the age of 23 at the time of application, who is an adopted child or stepchild pursuant to subsection (C) below, or a natural child who:

(A) lives with the subscriber or applicant; or

(B) is economically dependent upon the subscriber or the applicant.

(C) 1. A child shall be considered to be adopted from the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or applicant, or the spouse of a subscriber or applicant, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or applicant, or the spouse of a subscriber or applicant, to control the health care of the child placed for adoption.

2. A child shall be considered a stepchild upon the subscriber's or applicant's marriage to the natural or adopted stepchild's parent.

(3) An unmarried child over the age of 23 at the time of application, who is an adopted child or stepchild pursuant to (2)(C) of this section, or a natural child who at the time of attaining age 23 was incapable of self–support because of physical or mental disability which has existed continuously from a date prior to attainment of age 23.

(j) "Dependent Subscriber" means an enrolled dependent that has maintained eligibility pursuant to section 2698.205.

(k) "Disenroll" means termination from coverage by the program.

(*l*) "Eligible" means the applicant is qualified to be enrolled along with dependents in a participating health plan.

(m) "Enroll" means to accept an individual as a subscriber or as a dependent by notifying a participating health plan to accept the applicant and dependents, if any, for coverage.

(n) "Executive Director" means the Executive Director for the Board.

(o) "Fee–for–service plan" means either of the following:

(1) Service benefit plans under which retrospective payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services rendered to subscribers.

(2) Indemnity benefit plans under which a carrier agrees to pay retrospectively certain sums of money, not in excess of actual expenses incurred, for health services.

(p) "Health maintenance organization" means either of the following:

(1) Comprehensive group–practice prepayment plans which offer benefits, in whole or substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payments provided by the plans as full payment for covered services rendered by them.

(q) "Health plan" means a private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under chapter 11A (commencing with section 11491) of part 2 of division 2 of the Insurance Code, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (division 2 (commencing with section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it.

(r) "Medicare" means the Health Insurance for The Aged provided under title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in title XVIII of the Social Security Act.

(s) "Participating health plan" means a health plan which has a contract with the program to administer major risk medical coverage for pro-

gram subscribers. Participating health plans are categorized as either fee-for-service plans or health maintenance organizations as defined in section 2698.100(p) or (q) respectively.

(t) "Pilot Program" means the program established by Health and Safety Code section 1373.62 and Insurance Code section 10127.15.

(u) "Pilot Program health plan" means any health care service plan or health insurer who has enrolled a program graduate into the Pilot Program and a Pilot Program standard benefit plan.

(v) "Pilot Program standard benefit plan" means a benefit package that meets the criteria of Health and Safety Code section 1373.62(c) or Insurance Code section 10127.15 (c).

(w) "Pre-existing condition" means any condition for which medical advice, diagnosis, care, or treatment was recommended or received during a six month period immediately preceding the effective date of coverage.

(x) "Pre-existing condition exclusion period" means that period of time for which there is no coverage for a pre-existing condition.

(y) "Post-enrollment waiting period" means that period of time between the date of enrollment and the date coverage begins.

(z) "Program" means the California Major Risk Medical Insurance Program.

(aa) "Program Graduate" means:

(1) A subscriber in the Program who has completed 36 consecutive months of coverage and has been issued a Certificate of Program Completion by the Program; or

(2) A dependent subscriber who has completed a total of 36 consecutive months of coverage in the program, and has been issued a Certificate of Program Completion by the Program.

(bb) "Program Graduate dependent" means an enrolled dependent who has completed 36 consecutive months of coverage and has been issued a Certificate of Program Completion by the Program at the same time as the subscriber.

(cc) "Resident of the State of California" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes. However, a person who is absent from the state for a consecutive period greater than 210 days shall not be considered a resident.

(dd) "Standard average individual rate" means that rate a participating health plan estimates it would charge the general public for individual, non-group coverage for the benefits described in the program contract with the participating health plan.

(ee) "Standard monthly administrative fee" means the weighted monthly average per person administrative fee paid by the Pilot Program to participating Pilot Program health plans and calculated in accordance with section 2698.602(d).

(ff) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program. "Subscriber" does not include an individual receiving major risk medical coverage through the program as an enrolled dependent of a subscriber. An individual who is enrolled but not yet receiving coverage due to a post-enrollment waiting period is considered a subscriber.

(gg) "Subscriber contribution" means the amount paid by a subscriber or a dependent subscriber on a periodic basis to the program for coverage for a subscriber and/or enrolled dependents, if any, or for a dependent subscriber.

(hh) "Unique Identification Number (UIN)" means a number assigned by the Program to each Program Graduate's Certificate of Program Completion to be used in the Pilot Program to track each Program Graduate for payment and reporting purposes.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code; and ASSEM. Bill No. 1401 (stats. 2002, ch. 794, Sec. 21). Reference: Sections 10900, 10127.15, 12705, 12711, 12712, 12725, 12726 and 12730, Insurance Code; and Section 1373.62, Health and Safety Code.

HISTORY

1. New section filed 12-20-90 as an emergency; operative 12-20-90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4-19-91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-20-90 order including amendment of subsections (f) and (g) and NOTE transmitted to OAL 4-18-91 and filed 5-17-91 (Register 91, No. 27).
3. Editorial correction of printing errors (Register 91, No. 27).
4. New subsection (y) filed 6-27-91 as an emergency; operative 6-27-91 (Register 91, No. 40). A Certificate of Compliance must be transmitted to OAL by 10-25-91 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6-27-91 order including amendment of subsection (y) transmitted to OAL 10-23-91 and filed 11-22-91 (Register 92, No. 11).
6. Amendment of subsection (f) and NOTE filed 12-19-91 as an emergency; operative 12-19-91 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 4-17-92 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 12-19-91 order transmitted to OAL 4-8-92 and filed 5-12-92 (Register 92, No. 23).
8. Amendment of subsections (d), (f) and (p), new subsections (s)-(s)(4), subsection relettering, and amendment of newly designated subsection (z) and NOTE filed 5-19-95; operative 6-19-95 (Register 95, No. 20).
9. Editorial correction of article 1 heading (Register 96, No. 17).
10. Amendment of subsections (t) and (w) and repealer of subsection (z) filed 4-23-96; operative 5-23-96 (Register 96, No. 17).
11. Amendment of section and NOTE filed 8-4-2003 as an emergency; operative 8-4-2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2-2-2004 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 8-4-2003 order transmitted to OAL 1-23-2004 and filed 3-1-2004 (Register 2004, No. 10).

§ 2698.102. Terms.

For the purposes of this part:

(a) "Tenses and Number." The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

(b) "Time." Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.

HISTORY

1. New section filed 8-4-2003 as an emergency; operative 8-4-2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2-2-2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8-4-2003 order transmitted to OAL 1-23-2004 and filed 3-1-2004 (Register 2004, No. 10).

Article 2. Eligibility, Application, and Enrollment

§ 2698.200. Basis of Eligibility.

(a) All eligibility requirements contained herein shall be applied without regard to sex, race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.

(b) To be eligible for the program, an applicant shall meet the requirements of either (1) or (2):

(1) Meet all of the following requirements;

(A) Be a resident of the State of California; and

(B) Not be eligible for Part A and Part B of Medicare, except those applicants on Medicare solely because of end-stage renal disease; and

(C) Not be eligible to purchase any health insurance for continuation of benefits under the provisions of Health and Safety Code section 1366.20 et. seq., or under the provisions of Insurance Code section 10128.50 et. seq. or have exhausted any health insurance for continuation of benefits under the provisions of 29 US Code 1161 et. seq.; and

(D) Be unable to secure adequate private coverage. An individual shall be deemed unable to secure adequate private health coverage if the individual within the previous 12 months:

1. Has been denied individual coverage; or

2. Has been involuntarily terminated from health insurance coverage for reasons other than nonpayment of premium or fraud; or

3. Has been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

(2) Be a dependent of an individual meeting the requirements of (b)(1) of this section.

(c) To remain eligible a subscriber, enrolled dependent or dependent subscriber shall:

(1) Remain a resident of the State of California; and

(2) Not become eligible for Part A and Part B of Medicare, except those applicants who become eligible for Medicare solely because of end-stage renal disease; and

(3) Not exceed a total of 36 consecutive months of enrollment from his/her respective start of coverage date in the program as required by section 2698.204(a)(7); and

(4) Make subscriber contribution payments as required by section 2698.403.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725 and 12733, Insurance Code.

HISTORY

1. New section filed 12-20-90 as an emergency; operative 12-20-90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4-19-91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-20-90 order including amendment of subsections (a) and (b) transmitted to OAL 4-18-91 and filed 5-17-91 (Register 91, No. 27).
3. Amendment of subsection (b) filed 6-27-91 as an emergency; operative 6-27-91 (Register 91, No. 40). A Certificate of Compliance must be transmitted to OAL by 10-25-91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6-27-91 order transmitted to OAL 10-23-91 and filed 11-22-91 (Register 92, No. 11).
5. Amendment of subsections (b)(1)(B), (b)(1)(D)5., (c)(2) and NOTE filed 5-19-95; operative 6-19-95 (Register 95, No. 20).
6. Editorial correction inserting inadvertently omitted article 2 heading (Register 96, No. 17).
7. Repealer of subsection (b)(1)(D)4. and subsection renumbering, and amendment of newly designated subsection (b)(1)(D)4. filed 4-23-96; operative 5-23-96 (Register 96, No. 17).
8. Amendment of subsection (b)(1)(D)3. and repealer of subsection (b)(1)(D)4. filed 3-22-2002 as an emergency; operative 3-22-2002 (Register 2002, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-22-2002 or emergency language will be repealed by operation of law on the following day.
9. Editorial correction of HISTORY 8 (Register 2002, No. 35).
10. Certificate of Compliance as to 3-22-2002 order transmitted to OAL 7-19-2002 and filed 8-29-2002 (Register 2002, No. 35).
11. Amendment of subsections (b)(1)(C) and (c)-(c)(2) and new subsections (c)(3)-(4) filed 8-4-2003 as an emergency; operative 8-4-2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2-2-2004 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 8-4-2003 order transmitted to OAL 1-23-2004 and filed 3-1-2004 (Register 2004, No. 10).

§ 2698.201. Application.

(a) The Board shall establish an application review process which assures timely action on applications. The program shall complete the application review process within 30 days of the receipt of the application and payment of the initial subscriber contribution.

(b) To apply for the program an individual shall submit:

(1) all information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this section, and

(2) a check or money order for an amount equal to the initial subscriber contribution for the individual's first choice participating health plan.

(c) A complete application is one that meets the requirements of (b)(1) and (b)(2) of this section. All applications shall be reviewed for completeness upon receipt by the program.

(1) If the application is complete, it will be reviewed for an eligibility determination.

(2) An incomplete application shall be returned to the individual and shall not be processed.

(d)(1) The applicant shall use the application form entitled California Major Risk Medical Insurance Program Enrollment Application (December, 2003).

(2) The applicant shall provide the following information:

(A) The applicant's full name.

(B) The applicant's current home address including house or unit number, street, city, county, state, and zip code.

(C) The applicant's date of birth.

(D) The applicant's sex.

(E) The applicant's marital status.

(F) The applicant's home and/or business telephone number.

(G) If dependents are to be included in the coverage, the full names, dates of birth, sex, and relationship of the dependents to be covered.

(H) The name and address to which the bills for the subscriber contribution are to be sent, if different from the applicant's.

(I) Proof of rejection within 12 months of the date of application for health insurance coverage for reasons other than fraud or nonpayment of premium. The proof shall include a letter or other formal written communication from a health plan, documenting one or more of the following:

1. Having been denied health insurance coverage as an individual.

2. Having been involuntarily terminated from health insurance coverage.

3. Having been offered an individual, not a group, health insurance premium rate in excess of the subscriber rate for the individual's first choice participating health plan.

(J) An initialed declaration that the applicant is not eligible for Part A and Part B of Medicare, in accordance with subsection 2698.200(b)(1)(B).

(K) An initialed declaration that the applicant is a resident of the State of California.

(L) An initialed declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the applicant is enrolled.

(M) An initialed declaration that the applicant is not, to the applicant's knowledge, being excluded from a group for the purpose of being made eligible for the program.

(N) An initialed declaration that the applicant has reviewed the benefits offered by the participating health plans and the subscriber contribution rates.

(O) An initialed declaration that the applicant understands and will follow the rules and regulations of the program.

(P) Name and address of the applicant's primary employer, if employed.

(Q) The applicant's occupation, if employed.

(R) An initialed declaration that the applicant is not currently eligible to purchase any health insurance for continuation of benefits under the provisions of Health and Safety Code section 1366.20 et. seq., or under the provisions of Insurance Code section 10128.50 et. seq. or has exhausted any health insurance for continuation of benefits under the provisions of 29 US Code 1161 et. seq.

(S) An initialed declaration that the applicant has not been terminated from a standard benefit plan available under the provisions of Health and Safety Code section 1373.62 or Insurance code section 10127.15 within the last 12 months due to non-payment of premiums or as a result of the applicant's request to voluntarily disenroll or as a result of fraud.

(T) An indication of the applicant's selected participating health plan.

(U) If an applicant is not currently eligible for the program, but anticipates becoming eligible, the applicant shall explain and document the reason or reasons, and provide the date on which, eligibility will occur.

(V) The applicant or the applicant's parent, conservator, or guardian shall sign and date the application stating that the information given is true and correct.

(3) The following information is requested but not mandatory, and will be used for identification and administrative purposes:

(A) The applicant's ethnicity.

(B) The applicant's social security number.

(C) The dependent's social security number, if dependents are to be included in the coverage.

(e) In order for the program to determine that a pre–existing condition exclusion or a post–enrollment waiting period should be waived, or partially waived, each individual applying for coverage must provide one of the following:

(1) Documentation that the individual had prior creditable coverage, or

(2) Documentation that the individual has been covered by a similar plan sponsored by another state before becoming a resident of the State of California.

(f) Applications may be submitted at any time. An applicant shall not be enrolled nor shall the applicant be placed on a waiting list until the applicant has fulfilled all of the requirements for eligibility. Once the requirements for eligibility are fulfilled, applicants shall be enrolled or placed on a waiting list in order of the date of receipt of the completed application.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order including amendment of subsections (a) and (e) transmitted to OAL 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Amendment of subsection (e) filed 6–27–91 as an emergency; operative 6–27–91 (Register 91, No. 40). A Certificate of Compliance must be transmitted to OAL by 10–25–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6–27–91 order transmitted to OAL 10–23–91 and filed 11–22–91 (Register 92, No. 11).
5. Amendment of subsection (e)(1)(Q) and NOTE filed 8–11–92; operative 9–11–92 pursuant to Government Code section 11346.2(d) (Register 92, No. 34).
6. Amendment of subsections (e)(1)(H)5., (e)(1)(I), and (f)–(f)(1), repealer of subsection (f)(2) and subsection renumbering filed 5–19–95; operative 6–19–95 (Register 95, No. 20).
7. Amendment of subsection (e)(1), repealer of subsection (e)(1)(H)4. and subsection renumbering, and amendment of newly designated subsection (e)(1)(H)4. filed 4–23–96; operative 5–23–96 (Register 96, No. 17).
8. Repealer of subsection (e)(1)(H)4. filed 3–22–2002 as an emergency; operative 3–22–2002 (Register 2002, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–22–2002 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 3–22–2002 order transmitted to OAL 7–19–2002 and filed 8–29–2002 (Register 2002, No. 35).
10. Amendment filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 8–4–2003 order, including further amendment of subsection (d)(1), transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.202. Determination of Eligibility.

(a) Upon receipt of a complete application the program shall determine an applicant's eligibility based upon the criteria specified in section 2698.200.

(b)(1) Applicants determined ineligible shall be notified in writing by the program, except as in (2) below. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The applicant's initial subscriber contribution shall be refunded.

(2) If an applicant is determined to be currently ineligible, but the applicant has documented pursuant to section 2698.201(d)(2)(U) that he/she will become eligible, the applicant shall be notified that the application will be held until the eligibility date specified, and on that date the applicant will be determined eligible. The applicant's initial subscriber contribution shall not be refunded, unless the applicant's eligibility date is more than 60 days from the date of the notification.

(c) Applicants and any dependents determined eligible shall be either enrolled or placed on a waiting list and shall be notified of their status.

(d) Eligible applicants and any dependents shall be enrolled in accordance with section 2698.203, unless one of the following circumstances exist:

(1) There are no participating health plans offered in the applicant's county of residence.

(2) A program funding shortfall has been projected.

(e) When the circumstances in (d)(1) or (2) exist, applicants and any dependents shall be placed on a waiting list in the order in which their completed applications were received by the program. When health plans are offered or funds become available, whichever is applicable, applicants and any dependents shall be enrolled in accordance with section 2698.203 based upon the order in which they appear on the program's waiting list.

(f) The program shall refund the initial subscriber contribution to all applicants who have been on the program's waiting list for more than 60 days from the date their completed applications were received. Such applicants shall, within 30 days of notification by the program that enrollment is possible, pay the initial subscriber contribution and notify the program of any additional dependents to be enrolled.

(g) The program shall complete the enrollment of an applicant on the waiting list within 15 days of receipt of payment of the initial subscriber contribution that has met the requirements of (f) of this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of printing error (Register 91, No. 27).
4. New subsection (g) filed 12–19–91 as an emergency; operative 12–19–91 (Register 92, No. 11). A Certificate of Compliance must be transmitted to OAL 4–17–92 emergency language will be repealed by operation of law on the following day.
5. Amendment of subsection (f) filed 3–10–92 as an emergency; operative 3–10–92 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 7–8–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 12–19–91 order including amendment of subsection (g) transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 24).
7. Certificate of Compliance as to 3–10–92 order transmitted to OAL 6–30–92 and filed 7–29–92 (Register 92, No. 31).
8. Amendment of subsection (d), new subsection (e) and relettering and amendment of subsection (h) and NOTE filed 8–11–92; operative 9–11–92 pursuant to Government Code section 11346.2(d) (Register 92, No. 34).
9. Amendment filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.203. Enrollment.

(a) Providing neither of the circumstances specified in section 2698.202(d) exists, applicants determined eligible for the program shall be enrolled in an available participating health plan of the applicant's choice in the applicant's county of residence.

(b) If an applicant applied to have dependents covered, dependents shall also be enrolled in the subscriber's participating health plan.

(c) The date on which the coverage shall begin, subject to the provisions of section 2698.303, shall be the first day of the month following enrollment.

(d) An applicant shall be notified in writing by the program of enrollment with a participating health plan, the beginning date of coverage by the participating health plan, and of any pre–existing condition exclusion period or post–enrollment waiting period. The notice shall caution the applicant about discontinuing any existing coverage until full coverage by the participating health plan has begun.

NOTE: Authority cited: Sections 10127.15, 12711, 12712 and 12712.5, Insurance Code. Reference: Sections 12711, 12725 and 12728, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of subsection (d) (Register 95, No. 13).
4. Amendment of section and NOTE filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.204. Disenrollment.

(a) Disenrollment shall occur when:

(1) The subscriber requests in writing to be disenrolled or that an enrolled dependent be disenrolled.

(2) The enrolled dependent requests in writing to be disenrolled.

(3) The dependent subscriber requests in writing to be disenrolled.

(4) The subscriber or dependent subscriber fails to make subscriber contributions in accordance with section 2698.403.

(5) The subscriber, enrolled dependent or dependent subscriber no longer meets the residency requirement.

(6) The subscriber, enrolled dependent or dependent subscriber has notified the program in writing of his/her eligibility for Part A and Part B of Medicare or the program becomes aware of his/her eligibility for Part A and Part B of Medicare, except subscribers, enrolled dependents or dependent subscribers on Medicare solely because of end–stage renal disease.

(7) The subscriber, enrolled dependent or dependent subscriber has been enrolled in the program for a period of 36 consecutive months from his/her respective start of coverage date.

(A) If the subscriber, enrolled dependent or dependent subscriber was initially subject to a post–enrollment waiting period, the length of that post–enrollment waiting period shall not be calculated as part of his/her 36 consecutive months of enrollment.

(B) If the subscriber, enrolled dependent or dependent subscriber was initially subject to a pre–existing condition exclusion period, the length of that pre–existing condition exclusion period shall be calculated as a part of his/her 36 consecutive months of enrollment.

(8) The subscriber, enrolled dependent or dependent subscriber has committed an act of fraud to circumvent the statutes or regulations of the program.

(9) Death of a subscriber, enrolled dependent or dependent subscriber.

(b) The subscriber or dependent subscriber shall be notified by the program in writing of the disenrollment of the subscriber and/or enrolled dependents or the dependent subscriber, the reason for the disenrollment, the effective date of the disenrollment, and shall be given an explanation of the appeals process.

(c) Disenrollment pursuant to (a)(1) and (a)(2) and (a)(3) of this section shall be effective on the last day of the month in which the written request was received.

(d) Disenrollment pursuant to (a)(4) of this section shall be retroactive to the last day of the month for which the required subscriber contribution was paid in full.

(e) Disenrollment pursuant to (a)(5) of this section shall be effective on the last day of the month in which the program determines that the subscriber, enrolled dependent or dependent subscriber no longer meets the residency requirement.

(f) Disenrollment pursuant to (a)(6) of this section shall be effective on the last day of the month in which the subscriber's or the dependent subscriber's written notification that the subscriber and/or the enrolled dependent or the dependent subscriber is now eligible for Medicare Part A and Part B was received or on the last day of the month in which the program becomes aware of the subscriber's, enrolled dependent's or dependent subscriber's eligibility for Medicare Part A and Part B.

(g) Disenrollment pursuant to (a)(7) of this section shall be effective on the last day of the subscriber's, enrolled dependent's or dependent subscriber's 36th consecutive month of enrollment.

(1) The subscriber, enrolled dependent or dependent subscriber shall be notified by the program in writing of their disenrollment from the program, pursuant to (a)(7) of this section, 90 days in advance of the end of his/her 36th consecutive month of enrollment. The notice shall contain his/her effective date of disenrollment and shall provide information regarding the availability of guaranteed coverage in the private insurance market pursuant to Health and Safety Code section 1373.62 and Insurance Code section 10127.15.

(2) The program shall mail a second notice to the subscriber, enrolled dependent or dependent subscriber no less than 45 days in advance of the end of his/her 36th consecutive month of enrollment. The notice shall contain his/her effective date of disenrollment and a Certificate of Program Completion.

(h) Disenrollment pursuant to (a)(8) of this section shall be effective on the last day of the month in which the program determines that the subscriber, enrolled dependent or dependent subscriber has committed an act of fraud to circumvent the statutes or regulations of the program.

(i) Disenrollment pursuant to (a)(9) of this section shall be effective on the last day of the month in which death occurred.

(j) If disenrolled for any reason, a subscriber and enrolled dependent, if any, or a dependent subscriber shall not be eligible for enrollment in the program for 12 months from the date of disenrollment.

(k) Subscribers, enrolled dependents or dependent subscribers disenrolled pursuant to (a)(7) of this section who are eligible for the Pilot Program and elect that coverage, shall not be eligible for enrollment in the program for a period of 12 months from the date of disenrollment from the Pilot Program standard benefit plan if the disenrollment from the Pilot Program standard benefit plan was a result of:

(1) A request to voluntarily disenroll; or

(2) Non–payment of premiums due for the Pilot Program standard benefit plan; or

(3) An act of fraud.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code; and ASSEM. Bill No. 1401 (stats. 2002, ch. 794, Sec. 21). Reference: Sections 10127.15, 12711, 12733 and 12735, Insurance Code; and Section 1363.62, Health and Safety Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of printing error (Register 91, No. 27).
4. Amendment of subsections (a), (a)(3)–(a)(3)(B) and NOTE filed 12–19–91 as an emergency; operative 12–19–91 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 4–17–92 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 12–19–91 order including amendment of subsection (a)(3)(B) transmitted to OAL 4–8–92 and filed 5–12–92 (Register 92, No. 23).
6. New subsection (a)(5) and amendment of NOTE filed 8–11–92; operative 9–11–92 pursuant to Government Code section 11346.2(d) (Register 92, No. 34).
7. Amendment of subsection (a)(3)(B) filed 5–19–95; operative 6–19–95 (Register 95, No. 20).
8. Amendment of subsections (a)(2) and (b) filed 4–23–96; operative 5–23–96 (Register 96, No. 17).
9. Amendment of section and NOTE filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.205. Continuation of Benefits.

(a) If a subscriber is disenrolled pursuant to section 2698.204(a)(5) or 2698.204(a)(6) 2698.204(a)(7) or 2698.204(a)(9), an enrolled dependent shall be eligible for continued coverage in the program as a dependent subscriber for as long as he/she continues to meet the requirements of section 2698.200(c).

(b) If an enrolled dependent loses his or her dependent status due to divorce from the subscriber, the enrolled dependent shall be eligible for continued coverage in the program as a dependent subscriber for as long as he/she continues to meet the requirements of section 2698.200(c).

(c) An enrolled dependent that remains eligible pursuant to this section shall become a dependent subscriber and be subject to section 2698.204(a)(7), but shall not be required to demonstrate independent eligibility for the program.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Section 12730, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Amendment filed 12–19–91 as an emergency; operative 12–19–91 (Register 92, No. 19). A Certificate of Compliance must be transmitted to OAL 4–17–92 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–19–91 order transmitted to OAL 4–8–92 and filed 5–12–92 (Register 92, No. 23).
5. Repealer and new section filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.206. Dependent Coverage.

(a)(1) Dependents may be enrolled:

(A) Within sixty (60) days of the date the individual became the subscriber's dependent; or

(B) Within sixty (60) days of the termination of a dependent's other health care coverage.

(2) A subscriber wishing to enroll additional dependents shall notify the program in writing of the full names, dates of birth, sex, social security numbers (not mandatory), and relationship of the dependents to be enrolled. Social Security numbers and other personal information are used for identification and administrative purposes.

(3) In order for the program to determine that a pre–existing condition exclusion or post–enrollment waiting period should be waived, or partially waived, the subscriber may also provide the documentation required by section 2698.201(e) for each dependent to be added. If no documentation is provided, the dependent shall be subject to the maximum pre–existing condition exclusion or post–enrollment waiting period described in section 2698.303. Dependents age 18 and under are not subject to pre–existing condition exclusion or post–enrollment waiting periods.

(4)(A) Coverage for newborns and adopted children eligible pursuant to (a)(1) of this section shall begin upon birth or the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or the subscriber' spouse, the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the right of the subscriber or the subscriber's spouse, to control the health care of the child placed for adoption.

(B) Coverage for all other dependents eligible pursuant to (a)(1) of this section shall begin within 3 months of receipt of the notification to the program from the subscriber, and shall begin on the first day of a month, subject to the provisions of section 2698.303.

(5) Subscribers shall be notified in writing by the program of the beginning date of coverage by the subscriber's health plan for enrolled dependents, and, if applicable, of any pre–existing condition exclusion period or post–enrollment waiting period. The notice shall caution the subscriber about discontinuing any existing coverage for dependents until full coverage by the subscriber's health plan has begun.

(6) The subscriber contribution shall be adjusted as of a dependent's beginning date of coverage by the program; unless the dependent added was a newborn or an adopted child.

(7) The subscriber contribution for a newborn or an adopted child who is enrolled pursuant to (a)(1)(A) of this section shall be adjusted as of the first day of the month following the child's birth or first day of the month following the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the subscriber or the subscriber' spouse, the right to control health care for the adoptive child or, absent this written document, on the first day of the month following the date there exists evidence of the right of the subscriber or the subscriber's spouse, to control the health care of the child placed for adoption.

(b)(1) A subscriber wishing to disenroll dependents shall notify the program of the full names, dates of birth, sex, social security numbers, and relationship of the dependents to be disenrolled. Disenrollment of dependents shall be subject to sections 2698.204(a)(1), 2698.204(a)(2) and 2698.204(c).

(2) The subscriber contribution shall be adjusted, if applicable, as of the date of a dependent's disenrollment by the program.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12729, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order including amendment of subsection (a) transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of printing error (Register 91, No. 27).
4. Amendment of subsection (b)(3) and NOTE filed 4–23–96; operative 5–23–96 (Register 96, No. 17).
5. Amendment of section heading and section filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.207. Transfer of Enrollment.

(a) A subscriber and enrolled dependents, if any, or a dependent subscriber shall be transferred from one participating health plan to another if any of the following occurs:

(1) The subscriber or dependent subscriber so requests, in writing, during an open enrollment period established by the Board. The program shall inform each subscriber or dependent subscriber of each open enrollment period.

(2) The subscriber or dependent subscriber so requests, in writing, because the subscriber or dependent subscriber has moved and no longer resides in an area served by the participating health plan in which the subscriber or dependent subscriber is enrolled, and there is at least one participating health plan serving the area in which the subscriber or dependent subscriber now resides that is accepting new enrollees.

(3) The subscriber or dependent subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber–plan relationship and the executive director determines that the transfer is in the best interests of the program, and there is at least one participating health plan serving the area in which the subscriber or dependent subscriber resides that is accepting new enrollees.

(b) Subscribers, enrolled dependents and dependent subscribers who transfer enrollment pursuant to this section shall not be subject to pre–ex-

isting condition exclusions or post-enrollment waiting periods as specified in section 2698.303.

(c) Transfer of enrollment pursuant to (a)(1) shall take effect 30 days after the termination of an open enrollment period. Transfer of enrollment pursuant to (a)(2) or (a)(3) shall take effect within 35 days of approval of the request.

(d) Subscribers or dependent subscribers and participating health plans shall be notified in writing of any transfer of enrollment.

(e) If applicable, the subscriber contribution shall be adjusted as a result of a transfer of enrollment.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Section 12731, Insurance Code.

HISTORY

1. New section filed 12-20-90 as an emergency; operative 12-20-90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4-19-91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-20-90 order transmitted to OAL on 4-18-91 and filed 5-17-91 (Register 91, No. 27).
3. Editorial correction of printing error (Register 91, No. 27).
4. Amendment filed 8-4-2003 as an emergency; operative 8-4-2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2-2-2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 8-4-2003 order transmitted to OAL 1-23-2004 and filed 3-1-2004 (Register 2004, No. 10).

§ 2698.208. Payment to Insurance Agents and Brokers.

(a) If authorized by the board, the program shall pay an insurance agent as defined in section 31 of the Insurance Code or broker as defined in section 33 of the Insurance Code for assisting an individual in completing the application form, if the following conditions are met:

(1) The individual is enrolled as a result of the application;

(2) The agent or broker requests such payment in writing; and

(3) Such request accompanies the application and includes the name, license number, tax identification number or social security number, telephone number, and fax number (if available), signature, and address of the agent or broker.

(b) The amount of such payment shall be $50.00.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Sections 12711 and 12711.5, Insurance Code.

HISTORY

1. New section filed 12-20-90 as an emergency; operative 12-20-90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4-19-91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-20-90 order transmitted to OAL on 4-18-91 and filed 5-17-91 (Register 91, No. 27).
3. Amendment of subsection (a)(3) filed 8-4-2003 as an emergency; operative 8-4-2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2-2-2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8-4-2003 order transmitted to OAL 1-23-2004 and filed 3-1-2004 (Register 2004, No. 10).

Article 3. Minimum Scope of Benefits

§ 2698.300. Deductible and Copayment.

(a) Each participating health plan shall be permitted to require copayments and deductibles for benefits provided to a subscriber and enrolled dependents or dependent subscribers subject to the following limits:

(1) The copayment shall not exceed 25 percent of the cost of covered services. However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25).

(2) The deductible shall not exceed $500 annually for a household, which consists of a subscriber and any enrolled dependents or of a dependent subscriber.

(3) The sum of the copayment and deductible shall not exceed $2,500 annually for a subscriber or dependent subscriber or $4,000 annually for a subscriber and enrolled dependents.

(b) When a subscriber's or dependent subscriber's selected participating health plan is a plan that has contracts with certain listed providers from whom care is to be received for non-emergency conditions, and there are additional subscriber payments to providers other than those listed, such additional subscriber payments shall not be subject to the limits of this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12718, Insurance Code.

HISTORY

1. New section filed 12-20-90 as an emergency; operative 12-20-90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4-19-91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-20-90 order transmitted to OAL on 4-18-91 and filed 5-17-91 (Register 91, No. 27).
3. Editorial correction of printing error in subsection (b) (Register 91, No. 27).
4. Amendment of subsections (a)(1) and (a)(3) and amendment of NOTE filed 11-26-96 as an emergency; operative 1-1-97 (Register 96, No. 48). A Certificate of Compliance must be transmitted to OAL by 5-1-97 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 11-26-96 order transmitted to OAL 3-3-97 and filed 3-31-97 (Register 97, No. 14).
6. Amendment filed 8-4-2003 as an emergency; operative 8-4-2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2-2-2004 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 8-4-2003 order transmitted to OAL 1-23-2004 and filed 3-1-2004 (Register 2004, No. 10).

§ 2698.301. Minimum Scope of Benefits.

(a) The basic minimum scope of benefits offered by participating health plans to subscribers, dependent subscribers and enrolled dependents must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section. Except as required by the applicable statute and regulations, no other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic minimum scope of benefits shall be as follows:

(1) Hospital inpatient care in a hospital licensed pursuant to subdivision (a) of section 1250 of the Health and Safety Code, including all of the following benefits and services:

(A) Semi-private room, including meals and general nursing services; and private room and special diets when prescribed as medically necessary.

(B) Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, and anesthesia.

(C) Drugs, medications, and parenteral solutions administered while an inpatient.

(D) Dressings, casts, equipment, oxygen services, and radiation therapy.

(E) Respiratory and physical therapy.

(F) Diagnostic laboratory and x-ray services.

(G) Special duty nursing as medically necessary.

(H) Administration of blood and blood products.

(I) Other diagnostic, therapeutic or rehabilitative services (including occupational, physical and speech therapy) as appropriate.

(J) Medically necessary inpatient alcohol and substance abuse detoxification.

(K) General anesthesia and associated facility charges in connection with dental procedures rendered in a hospital, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. This benefit is only available to subscribers, enrolled dependents or dependent sub-

scribers under seven years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(2) Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

(A) Physician services including consultations, referrals, office and hospital visits and surgical services performed by a physician and surgeon.

(B) Diagnostic laboratory services, diagnostic and therapeutic radiological services and other diagnostic services that shall include but not limited to nuclear medicine, ultrasound, electrocardiography and electroencephalography.

(C) Dressings, casts and use of castroom, anesthesia, and oxygen services when medically necessary.

(D) Blood, blood derivatives and their administration.

(E) Radiation therapy and chemotherapy, of proven benefit.

(F) Comprehensive preventive care of children, 16 years of age or younger which is consistent with the Recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics in September of 1987, and the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Comprehensive preventive care services shall in include periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.

(G) General anesthesia and associated facility charges in connection with dental procedures rendered in a surgery center setting, when the clinical status or underlying medical condition of a subscriber, enrolled dependent or dependent subscriber requires dental procedures that ordinarily would not require general anesthesia to be rendered in a surgery center setting. This benefit is only available to subscribers, enrolled dependents or dependent subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers, enrolled dependents or dependent subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require a participating health plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist.

(H) Nothing in this section shall preclude the reimbursement of physician assistants, nurse practitioners or other advanced practice nurses who provide covered services within their scope of licensure.

(3) Family planning services including a variety of prescriptive contraceptive methods approved by the federal Food and Drug Administration, and reproductive sterilization.

(4) Comprehensive maternity and perinatal care, including the services of a physician and surgeon, certified nurse midwife or nurse practitioner, and all necessary hospital services, including services relating to complications of pregnancy, are covered services. Nothing in this section shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services.

(5) Emergency care including out–of–area coverage. Emergency ambulance transportation including transportation provided through the "911" emergency response system.

(6) Reconstructive Surgery: Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following;

(A) improve function.

(B) create a normal appearance to the extent possible.

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(7) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration, generic equivalents approved as substitutable by the federal Food and Drug Administration, or drugs approved by the federal Food and Drug Administration as Treatment Investigational New Drugs. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non–insulin dependent and gestational diabetes.

(8) Mental Health benefits, are covered as follows:

(A) For severe mental illnesses, and serious emotional disturbances of children, inpatient services, outpatient services, partial hospitalization services and prescription medications. Severe mental illnesses include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive–compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

(B) Except as specified in Subsection (A) above, mental health benefits are limited to the following:

1. Inpatient care for a period of 10 days in each calendar year.

2. 15 outpatient visits in each calendar year.

(9) Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate on an outpatient basis.

(10) Durable medical equipment, including prosthetics to restore and achieve symmetry incident to a mastectomy and to restore a method of speaking incident to a laryngectomy. Covered services also include blood glucose monitors and blood glucose monitors for the visually impaired for insulin dependent, non–insulin dependent and gestational diabetes; insulin pumps and all related necessary supplies; visual aids to assist the visually impaired with proper dosing of insulin and podiatric devices to prevent or treat diabetes complications.

(11) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

(12) The following human organ transplants: corneal, human heart, heart–lung, liver, bone–marrow and kidney transplantation. Transplants other than corneal shall be subject to the following restrictions:

(A) Pre–operative evaluation, surgery, and follow–up care shall be provided at centers that have been designated by the participating health plan as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.

(B) Patients shall be selected by the patient–selection committee of the designated centers and subject to prior authorization.

(C) Only anti–rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

(13) Hospice services pursuant to Health and Safety Code section 1368.2.

(14) This part shall not be construed to prohibit a plan's ability to impose cost–control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order including amendment of subsections (a)(3), (8) and (11), transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of printing error in subsection (a)(1)(C) (Register 91, No. 27).
4. Amendment of section and NOTE filed 3–22–2002 as an emergency; operative 3–22–2002 (Register 2002, No. 12). A Certificate of Compliance must be trans-

mitted to OAL by 7–22–2002 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 3–22–2002 order, including further amendment of subsections (a)(1)(I), (a)(9) and (a)(11) transmitted to OAL 7–19–2002 and filed 8–29–2002 (Register 2002, No. 35).
6. Amendment of subsections (a), (a)(1)(K), (a)(2)(G) and (a)(8)(A), repealer of subsection (a)(12)(C) and subsection relettering filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.302. Excluded Benefits.

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

(1) Services that are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage.

(3) Custodial, domiciliary care, or rest cures for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self–administered.

(4) Personal or comfort items, or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:

(A) Services, products, drugs or devices which are experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(B) Outmoded or not efficacious.

(7) Transportation except as specified in section 2698.301(a)(5).

(8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in section 2698.301(a)(6).

(9) Sex change operations, investigation of or treatment for infertility, reversal of sterilization, and conception by artificial means.

(10) Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care for minors," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care are excluded.

(11) Long–term care benefits including home care, skilled nursing care, and respite care, are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits.

(12) Dental services and services for temporomandibular joint problems are excluded, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible.

This language shall not be construed to exclude surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.

(13) Treatment of chemical dependency except as specified in section 2698.301(a)(1)(J).

(14) Cosmetic surgery, except as specifically provided in section 2698.301(a)(6).

(b) Benefits which exceed $75,000 in a calendar year under the program for a subscriber, a subscriber's enrolled dependent or a dependent subscriber shall be excluded.

(c) Benefits which exceed $750,000 in a lifetime under the program for a subscriber, a subscriber's enrolled dependent or dependent subscriber shall be excluded. Benefits received prior to January 1, 1999 shall be counted toward the $750,000 lifetime maximum.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12712, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of printing error in subsection (a)(8) (Register 91, No. 27).
4. Amendment of subsection (a)(14) and NOTE filed 1–14–93; operative 2–16–93 (Register 93, No. 3).
5. Amendment of subsections (b) and (c) filed 12–24–98 as an emergency; operative 12–24–98 (Register 98, No. 52). A Certificate of Compliance must be transmitted to OAL by 4–23–99 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 12–24–98 order transmitted to OAL 4–6–99 and filed 5–10–99 (Register 99, No. 20).
7. Amendment of subsections (a)(7)–(10), (a)(12)–(13), (a)(15) and (b)–(c) filed 3–22–2002 as an emergency; operative 3–22–2002 (Register 2002, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–22–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3–22–2002 order, including further amendment of subsection (a)(13), repealer of subsection (a)(14), subsection renumbering and amendment of newly designated subsection (a)(15), transmitted to OAL 7–19–2002 and filed 8–29–2002 (Register 2002, No. 35).
9. Amendment of subsections (a)(11) and (a)(13)–(14), repealer of subsection (a)(15) and amendment of subsections (b)–(c) filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.303. Pre–Existing Condition Exclusion and Post–Enrollment Waiting Period.

(a) Unless a waiver is granted pursuant to subsection (c), subscribers and enrolled dependents who enroll in a health maintenance organization participating health plan shall be subject to a post–enrollment waiting period. The post–enrollment waiting period shall apply to all subscribers and enrolled dependents. Subscribers shall not be required to pay subscriber contributions during the waiting period. The post–enrollment waiting period shall be 3 months unless reduced pursuant to subsection (d).

(b) Unless a waiver is granted pursuant to subsection (c), subscribers and enrolled dependents who enroll in a fee–for–service participating health plan shall be subject to a pre–existing condition exclusion period. During the pre–existing condition exclusion period no benefits or services related to a pre–existing condition shall be covered. Subscribers shall be required to pay subscriber contributions during the pre–existing condition exclusion period. The pre–existing condition exclusion period shall be 3 months unless reduced pursuant to subsection (d).

(c) Waivers or partial waivers to the post–enrollment waiting period or pre–existing condition exclusion period shall be granted for each individual subscriber or enrolled dependent providing any of the following criteria are met:

(1) The subscriber and/or enrolled dependent applies for the program within 180 days of the termination of prior creditable coverage, and such coverage was terminated due to:

(A) a loss of employment,

(B) the employer stopped offering or sponsoring health coverage, or

(C) the employer stopped making contributions towards health coverage.

(2) If the subscriber or enrolled dependent applies for the program within 63 days of the termination of prior creditable coverage and such coverage was terminated due to reasons other than:

(A) the criteria in (c)(1)(A), (B), or (C) of this section;

(B) non–payment of premiums; or

(C) fraud.

(3) The subscriber or dependent(s) who had previously received coverage under a similar program in another state within the last 12 months, shall be granted a full waiver of 3 months.

(4) A dependent age 18 and under who enrolled pursuant to section 2698.206 shall be granted a full waiver of 3 months.

(5) The subscriber who was on the program waiting list in accordance with Section 2698.202 for 180 days or longer shall be granted a full waiver of 3 months. A full waiver of 3 months shall also be granted for any dependents enrolled at the same time as the subscriber.

(d) Waivers or partial waivers to the post–enrollment waiting period or pre–existing condition exclusion period for individuals meeting the requirements of (c)(1) or (c)(2) of this section shall be calculated as follows:

(1) If the prior creditable coverage was for 3 consecutive months or more, a full waiver of 3 consecutive months shall be granted.

(2) If the prior creditable coverage was for 2 consecutive months, a partial waiver of 2 consecutive months shall be granted.

(3) If the prior creditable coverage was for 1 month, a partial waiver of 1 month shall be granted.

(4) If the prior creditable coverage was for less than 1 month, no waiver shall be granted.

(e) The program shall fully explain to applicants the type of health care coverage offered by each participating health plan, including the applicable waiting/exclusion periods specified in this section.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12726, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Amendment of subsection (c)(4) filed 7–10–91 as an emergency; operative 7–10–91 (Register 91, No. 43). A Certificate of Compliance must be transmitted to OAL by 11–7–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–10–91 order including amendment of subsection (c)(4) transmitted to OAL 10–23–91 and filed 11–21–91 (Register 92, No. 8).
5. New subsection (c)(5) filed 3–10–92 as an emergency; operative 3–10–92 (Register 92, No 19). A Certificate of Compliance must be transmitted to OAL 7–8–92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 3–10–92 order transmitted to OAL 6–30–92 and filed 7–29–92 (Register 92, No. 31).
7. Amendment of section and NOTE filed 5–19–95; operative 6–19–95 (Register 95, No. 20).
8. Amendment of section heading and section filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

Article 4. Risk Categories and Subscriber Contributions

§ 2698.400. Risk Categories.

(a) The risk categories on which the program and subscriber contributions are to be determined shall be the following;

(1) Six (6) geographic regions:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) twelve (12) age groups:

(A) Under 15 years of age;

(B) 15–29 years of age;

(C) 30–34 years of age;

(D) 35–39 years of age;

(E) 40–44 years of age;

(F) 45–49 years of age;

(G) 50–54 years of age;

(H) 55–59 years of age;

(I) 60–64 years of age;

(J) 65–69 years of age;

(K) 70–74 years of age; and

(L) 75 years of age and over.

(b) No other risk categories shall be allowed for the purpose of this program.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Section 12736, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).

§ 2698.401. Determination of Subscriber Contribution.

(a) Each participating health plan shall provide an annual estimate of the standard average individual rate for the minimum benefits provided for in the contract with the participating health plan for each risk category specified in section 2698.400. Without applying risk categories to dependents or dependent subscribers, each participating health plan shall also provide an estimate of the standard average rate for covering a subscriber in each risk category and the subscriber's dependents as follows:

(1) A subscriber and one dependent; and

(2) A subscriber and two or more dependents.

(b) For those participating health plans which have been offered through the program for two or more years, the Board shall calculate a loss ratio for each participating health plan for the prior calendar year. The loss ratio shall be calculated using 125 percent of the estimated rates provided by the participating plan as the denominator, and the sum of all medical costs for subscribers, dependent subscribers and dependents enrolled in the plan and all administration fees and risk payments to the plan as the numerator.

(c) For those participating health plans which have been offered through the program for two or more years, the Board shall calculate a

percentage average subsidy amount per subscriber dollar contributed for each participating health plan for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.

(d) The Board shall calculate the program loss ratio for the prior calendar year in the following manner:

(1) Participating health plans with an average monthly number of enrollees of fewer than 1,000 in the prior calendar year shall be excluded from the calculation.

(2) If a participating health plan's loss ratio is less than 100 percent it shall be deemed to be 100 percent for purposes of the calculation.

(3) The weighted average of the participating health plans' loss ratios is the program loss ratio.

(e) The Board shall calculate the program average subsidy for the prior calendar year by subtracting 100 percent from the program loss ratio percentage.

(f) For each participating health plan with an average subsidy percentage amount higher than the program average subsidy percentage, that difference shall be called the excess subsidy.

(g) The Board shall determine the subscriber contribution for each participating health plan that did not have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by 125 percent.

(h) The Board shall determine the base subscriber contribution for each participating health plan that did have an excess subsidy in the prior calendar year by multiplying the estimated rates provided by the participating health plan by an additional 25 percent and then adding the excess subsidy amount. However, the actual subscriber contribution shall be subject to the following limitations:

(1) No subscriber contribution will be more than 10 percent above 125 percent of the estimated rates provided by the participating plan. (See Title 10, section 2698.100(dd).)

(2) If all participating health plans available in a county have an excess subsidy amount, the subscriber contribution for the plan with the lowest excess subsidy amount will not include the excess subsidy amount.

(i) Subscriber contribution for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the estimated rates provided by the participating plan for the first two benefit years the plan participates in the program. (See Title 10, section 2698.100(dd).)

(j) Subscriber contributions shall be adjusted annually in accordance with this section.

(k) Subscribers and dependent subscribers shall be informed by the program of the annually adjusted subscriber contribution at least one month prior to the effective date of the rate change.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12713, 12736, 12737 and 12738, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Repealer and new subsection (b), new subsections (c)–(i), subsection relettering, amendment of newly designated subsection (j), and amendment of NOTE filed 11–26–96 as an emergency; operative 1–1–97 (Register 96, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–1–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 11–26–96 order transmitted to OAL 3–3–97 and filed 3–31–97 (Register 97, No. 14).
5. Amendment of subsections (a)–(b), (h)(1), (i) and (k) filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.403. Subscriber Contribution Payments.

Subscriber contribution payment procedures shall be as follows:

(a) Each month the program shall determine the amount of the subscriber contribution in accordance with sections 2698.400 and 2698.401 and notify the subscriber or dependent subscriber of the subscriber contribution amount due to the program and the due date. The program shall send the notice at least 30 days in advance of the due date.

(b) A subscriber or dependent subscriber shall submit the subscriber contribution to the program each month so that it is received no later than the first of each month for that month of coverage.

(c) The obligation to submit the subscriber contribution amount required by subsection (b) above is not contingent upon receipt of the notice specified in subsection (a). If the subscriber or dependent subscriber does not receive the notice specified in subsection (a) above, the subscriber or dependent subscriber shall make a good faith effort to determine the amount of the subscriber contribution and shall submit a payment of that amount by the due date.

(d) The subscriber contribution amount shall be calculated based on the subscriber's or the dependent subscriber's age as defined in section 2698.400.

(e) Adjustments to the subscriber contribution amount due to a change in the subscriber's or the dependent subscriber's age group as defined in section 2698.400 shall occur on the first day of the month following the subscriber's or the dependent subscriber's birth date.

(f) The subscriber contribution amount for a dependent subscriber shall be adjusted on the first of the month following the dependent's divorce, or the subscriber's disenrollment from the program. The adjusted subscriber contribution amount shall be calculated based on the dependent subscriber's age as defined in section 2698.400.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12737, Insurance Code.

HISTORY

1. New section filed 4–23–96; operative 5–23–96 (Register 96, No. 17).
2. Amendment filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.405. Overdue Payments.

(a) A subscriber or dependent subscriber whose subscriber contribution is not paid in full for any reason by the due date shall be considered to be overdue.

(b) The program shall notify the subscriber or dependent subscriber of the overdue subscriber contribution payment amount and the potential for disenrollment from the program on the 10th day following the due date when the current month's premium is paid before the next month's due date. An exception to this is specified in subsection (c).

(c) When the previous month's subscriber contribution is received on the due date for the current month, a final notice notice will be generated on the 15th day following the due date for the current month.

(d) Subscriber contributions more than 31 days overdue shall result in the subscriber and any enrolled dependents or the dependent subscriber being disenrolled pursuant to section 2698.204.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12735, Insurance Code.

HISTORY

1. New section filed 4–23–96; operative 5–23–96 (Register 96, No. 17).
2. Amendment filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.407. Reinstatement.

(a) A subscriber and enrolled dependents, if any, or a dependent subscriber who is disenrolled for nonpayment of the subscriber contribution may be reinstated once during a rolling twelve (12) month period if the subscriber or dependent subscriber requests reinstatement within sixty

(60) days of the date of the disenrollment action and brings all delinquent payments up to date.

(b) A subscriber and enrolled dependents, if any, or a dependent subscriber who is disenrolled more than once during a rolling twelve (12) month period for nonpayment of the subscriber contribution may only be reinstated through an appeal to the board as set forth in Section 2698.500 except as specified in subsection (c).

(c) A subscriber and enrolled dependents, if any, or a dependent subscriber who has been disenrolled due to the submission of two checks which were returned for insufficient funds during a rolling twelve (12) month period will not be reinstated.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Section 12735, Insurance Code.

HISTORY

1. New section filed 4–23–96; operative 5–23–96 (Register 96, No. 17).
2. Amendment of subsection (a), new subsection (b), and subsection relettering filed 12–10–97; operative 1–9–98 (Register 97, No. 50).
3. Amendment filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

Article 5. Appeals

§ 2698.500. Appeals to the Board.

(a) Any subscriber, enrolled dependent or dependent subscriber who is dissatisfied with any action or failure to act which has occurred in connection with a participating health plan's coverage may file an appeal with the Board.

(b) In addition, the following decisions may be appealed to the Executive Director only:

(1) A program determination as to eligibility of any applicant or the applicant's dependents.

(2) A program determination to disenroll a subscriber, enrolled dependent or dependent subscriber from the program.

(3) A program determination to deny a subscriber or dependent subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Amendment of subsection (b) and NOTE filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).
5. Amendment of subsections (a), (b)(2) and (b)(3) filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.501. Dispute Resolution.

Notwithstanding other sections in this Article, when a subscriber, enrolled dependent or dependent subscriber is dissatisfied with any action, or inaction, of the program's participating health plan in which he/she is enrolled, the subscriber, enrolled dependent or dependent subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Amendment filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.502. Filing an Appeal.

(a) An appeal shall be filed in writing with the Executive Director within sixty (60) days of the action or failure to act or receipt of notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed; or a written statement of the action or failure to act being appealed;

(2) A statement specifically describing the issues which are disputed by the appellant;

(3) A statement of the resolution requested by the appellant; and

(4) Any other relevant information the appellant wants to include.

(c) Any appeal that does not include all necessary information shall be returned to the appellant without review. The appellant may re–submit the appeal within the time limits of subsection (a) or within twenty (20) days of the receipt of the returned appeal, whichever is later.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Repealer of subsections (c)–(c)(2), subsection relettering, and amendment of NOTE filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).
5. Amendment of subsections (a) and (c) filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.503. Administrative Review.

(a) Any appeal filed pursuant to this Article will be given an administrative review.

(b) Administrative reviews of appeals shall be conducted by the Executive Director.

(c) In conducting an administrative review of an appeal, the Executive Director may contact the appellant and/or the participating health plan for further information.

(d) The Executive Director's decision shall be in writing.

(e) If an appeal was filed pursuant to section 2698.500(a), the appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the Executive Director. Such a request shall be filed within thirty (30) days of receipt of the Executive Director's decision. It shall include a clear and concise statement of what action is being appealed, and the reason(s) the Executive Director's decision is not correct.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Amendment of subsections (a), (e) and NOTE filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).
5. Amendment of subsection (e) filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.504. Hearings.

Upon receipt of an appeal which requests an administrative hearing, the Board shall determine the appropriate forum as follows:

(a) An appeal filed pursuant to subsection (a) of section 2698.500 shall be reviewed by the Board to determine whether it is practicable to have the hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The Board will determine practicability by considering such issues as timing, location and costs to the parties. If it is determined to be practicable, such a hearing shall be scheduled. If it is determined not to be practicable, the appeal shall be heard in accordance with subsection (b) of this Section.

(b) An appeal filed pursuant to subsection (a) of section 2698.500 but which it has been determined by the Board should be heard in accordance with this subsection, shall be heard according to the appeal procedures, including pre– and post–hearing procedures, set forth in Chapter 2.5 (commencing with section 251) of Division 2 of Title 1 of the California Code of Regulations. Chapter 2.5, as adopted on June 4, 1984, is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private non–profit human service organization shall be deemed reference to the petitioner.

(3) Reference to the grievance procedure established in accordance with Health and Safety Code section 38036 shall be deemed reference to the administrative review process set forth in section 2698.503.

(4) Reference to Health and Safety Code sections providing the bases, grounds, authorization or procedures for appeals shall be deemed reference to the bases and authorization for appeal found in section 2698.500, and the appeal procedures found in this section.

(5) The 30–day time period specified in section 251(b) shall be extended to 60 days, and the 10–day time period in section 252(a) shall be extended to 30 days.

(6) If the proposed decision submitted to the Board is not adopted as the decision, the Board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(7) The decision of the Board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 18–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27).
3. Editorial correction of printing error in subsection (b) (Register 91, No. 27).
4. Amendment of subsection (b), new subsections (b)(1)–(7) and amendment of NOTE filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 1–10–95 order including amendment of subsections (a)–(b) transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).
6. Amendment of subsections (a) and (b) filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.505. Conduct of Hearing by Hearing Officer.

NOTE: Authority cited: Sections 12711 and 12712, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. Certificate of Compliance as to 12–20–90 order repealing former section 2698.505 and renumbering former section 2698.506 to section 2698.505 transmitted to OAL 4–18–91 and filed 5–17–91 (Register 91, No. 27). For prior history, see Register 91, No. 11.
2. Amendment of subsection (b) and NOTE filed 1–11–93; operative 2–10–93 (Register 93, No. 3).
3. Repealer filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

§ 2698.506. Decision on Appeal Hearing by Hearing Officer.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. Certificate of Compliance as to 12–20–90 order renumbering former section 2698.506 to section 2698.505 and renumbering former section 2698.507 to section 2698.506 transmitted to OAL on 4–18–91 and filed 5–17–91 (Register 91, No. 27). For prior history, see Register 91, No. 11.
2. Editorial correction of subsection (b) (Register 91, No. 27).
3. Repealer filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 1 (Register 95, No. 13).
5. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

§ 2698.507. Decision on Appeal Hearing by Hearing Officer.

NOTE: Authority cited: Sections 12711, 12712 and 12712.5, Insurance Code. Reference: Sections 12711 and 12732, Insurance Code.

HISTORY

1. New section filed 12–20–90 as an emergency; operative 12–20–90 (Register 91, No. 11). A Certificate of Compliance must be transmitted to OAL by 4–19–91 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–20–90 order renumbering former section 2698.507 to section 2698.506 transmitted to OAL 5–17–90 and filed 5–17–91 (Register 91, No. 27).

Article 6. Pilot Program Payments

§ 2698.600. Semiannual Interim Payment and Reporting Procedures for Pilot Program Health Plans.

(a) The semiannual interim payment process for Pilot Program payment shall occur starting at the end of the first reporting period, September 1, 2003 through December 31, 2003, and on June 30 and December 31 of each year thereafter, as long as there are Program Graduates or Pro-

gram Graduate dependents enrolled. In order to qualify for a semiannual interim payment a Pilot Program health plan shall submit a semiannual interim enrollment report no later than 90 days after the semiannual reporting period as established above in this section. If a Pilot Program health plan does not submit a semiannual interim enrollment report by the end of the 90 day period, the plan will not receive an interim payment for that period.

(b) The semiannual interim enrollment report shall be submitted for each program graduate enrolled in the Pilot Program standard benefit plan during the semiannual interim period, and consist of:

(1) A signed certification that all program graduates for whom the Pilot Program health plan has made claim are enrolled in a Pilot Program standard benefit plan.

(2) The following information, to be submitted electronically, in a format specified by the Board, which consists of the following elements for each Program Graduate enrolled in the Pilot Program standard benefit plan during the semiannual interim period:

(A) The Program Graduate's unique identification number,

(B) The Pilot Program health plan's own identification number for the Program Graduate,

(C) The Program Graduate's full name,

(D) The Program Graduate's home address including house or unit number, street, city, county, state, and zip code,

(E) The name of each Program Graduate dependent who is covered under the Pilot Program at the same time as the program graduate,

(F) The date of birth of each Program Graduate and Program Graduate dependent,

(G) The Program Graduate's and any Program Graduate dependent's date of disenrollment from the Program, as indicated on the Certificate of Program Completion,

(H) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan,

(I) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan, when transferred from one Pilot Program health plan to another.

(J) The Program Graduate's and any Program Graduate dependent's date of disenrollment in the Pilot Program health plan, if disenrollment has occurred during the interim semiannual reporting period.

(3) The semiannual interim enrollment report shall include an estimate, adjusted for incurred but not reported (IBNR) costs, of the amount expended for program graduates and program graduate dependents, and the total amount of premium payments received to the Pilot Program health plan during the reporting period.

(c) The Board will issue an interim payment no later then 60 days after receipt of a valid semiannual interim payment report, consisting of all the elements as stated above in subsection (b). The payment will be determined using the following formula for each individual:

the most recent average premium as established by the Board during its semiannual determination of estimated enrollment times one half (the absolute value of the prior calendar year loss ratio minus 110 percent)

(d) The semiannual interim payment reporting process shall be subject to review and/or audit by the Board or its authorized representative in order to verify Program Graduates, and Program Graduate dependents, enrollment through a Pilot Program health plan in the Pilot Program standard benefit plan, for a period of four years after an interim payment has been made.

NOTE: Authority cited: Section 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

HISTORY

1. New article 6 (sections 2698.600–2698.604) and section filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.602. Annual Reconciliation Reporting and Payment Process for Pilot Program Health Plans.

(a) The time period for annual reconciliation, reports and payment shall be as follows:

(1) The annual reconciliation reporting and payment process shall start one year after the end of each reporting period established in Health and Safety Code Section 1373.62(g)(1) and Insurance Code 10127.15 (g)(1). These periods are as follows:

September 1, 2003, to December 31, 2003, inclusive,
January 1, 2004, to December 31, 2004, inclusive,
January 1, 2005, to December 31, 2005, inclusive,
January 1, 2006, to December 31, 2006, inclusive,
January 1, 2007, to August 30, 2007, inclusive.

(2) However, for the purpose of reconciliation and payment, the January 1, 2007 to August 30, 2007 reporting period shall be extended through December 31, 2007, and shall include Program Graduates and Program Graduate dependents that remain enrolled in a Pilot Program health plan's standard benefit plan on September 1, 2007 (the day the Pilot Program becomes inoperative). Pilot Program health plans with such program graduates or program graduate dependents may continue to report, and be eligible for reconciliation and payment, one year after the close of each calendar year until the plan no longer has any remaining program graduates or program graduate dependents.

(b) In order to qualify for annual reconciliations, a Pilot Program health plan shall submit an annual report by December 31 of each year, starting in December 2004. Pilot Program health plans who submit these reports by the established due dates will be given priority for reconciliation and any resulting payments. Pilot Program health plans who submit reports after the established due dates will be reconciled, and any resulting payments made from available funds, in order of the day of receipt of the report.

(c) The annual report to be submitted by Pilot Program health plans shall consist of three parts:

(1) For a Program Graduate and a Program Graduate dependent enrolled in a Pilot Program standard benefit plan, an enrollment and program report to be submitted electronically, in a format to be specified by the Board, for the reporting periods established above in subsection (a)(1) and (2):

(A) The Program Graduate's unique identification number,

(B) The Pilot Program health plan's own identification number for the Program Graduate.

(C) The Program Graduate's full name,

(D) The Program Graduate's home address including house or unit number, street, city, county, state and zip code,

(E) The name of each Program Graduate dependent who is covered under the Pilot Program at the same time as the Program Graduate,

(F) The date of birth of each Program Graduate and Program Graduate dependent,

(G) The Program Graduate's and any Program Graduate dependent's date of disenrollment from the Program, as indicated on the Certificate of Program Completion,

(H) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan,

(I) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan, when transferred from one Pilot Program health plan to another.

(J) The Program Graduate's and any Program Graduate dependent's date of disenrollment in the Pilot Program health plan, if disenrollment has occurred during the annual reporting period, and if disenrollment was the result of any of the following:

1. Program Graduate's request;
2. eligibility for Medicare Part A and Part B;
3. eligibility for other health insurance;

4. non–payment of premiums;
5. fraud;
6. death; or
7. other.

(K) Dollar amount of all premiums paid by, or on behalf of each Program Graduate, and Program Graduate dependent for coverage in the Pilot Program standard benefit plan during the reporting period.

(2) A claims report, to be provided electronically for each program graduate and program graduate dependent enrolled with the Pilot Program health plan for service provided and expense payments made during the annual reporting period. The reporting expense payments shall be limited to expense payments made to providers of services and shall not include the Pilot Program health plan administrative expenses, and shall not include incurred but not reported costs. The report, entitled "Major Risk Medical Insurance Pilot Program Health Plan and Claims Reporting File Layout and Field Description, dated September, 2003 is hereby incorporated by reference.

(3) A signed certification that all program graduates for whom the Pilot Program health plan has made claim are enrolled in a Pilot Program standard benefit plan.

(4) An incomplete report shall be returned with an explanation to the Pilot Program health plan of the reasons for incompleteness.

(d) The Board will review and reconcile each annual complete report within 120 days of receipt to the Pilot Program health plan of the findings based on the following formula:

one half (aggregate claims minus aggregate premiums) plus aggregate standard monthly administrative fee minus semiannual interim payments paid for that reporting period equals Final Payment.

In order to determine an aggregate monthly administrative fee for individuals in the Pilot Program, the Board will use a weighted average, weighted by plan population and adjusted by a factor of the number of dependents in the Program, of the current administrative fees for plans participating in the Program.

(1) The Board may make adjustments in determining the final payment to any Pilot Program health plan as follows:

(A) to delete any payments for persons who cannot be determined to be a Program Graduate or Program Graduate dependent during the reporting period,

(B) to delete expenses for services beyond the date of disenrollment during a reporting period for a Program Graduate or Program Graduate dependent,

(C) to delete expenses for services for the Program Graduate or Program Graduate dependent beyond the date of eligibility for Medicare Part A and Medicare Part B, and who are not in Medicare solely because of end stage renal disease,

(D) to delete expenses that occurred for services outside of the reporting period, and

(E) to delete all expenses beyond the $200,000 annual and $750,000 lifetime benefit limits for each individual in a Pilot Program standard benefit plan.

(2) If the current reconciliation indicates that further payment is owed to the Pilot Program health plan, the payment shall be made 30 days after notification of the reconciliation results. If the annual reconciliation indicates that an overpayment has been made through the semiannual interim payment process, the Pilot Program health plan shall pay the overpayment to the Board within 35 days after the notification of reconciliation.

(e) The annual reconciliation, reporting and payment process shall be subject to review and/or audit by the Board or its authorized representatives, for a period of four years after a reconciliation payment by either the Board or a Pilot Program health plan has been made.

NOTE: Authority cited: Section 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

HISTORY

1. New section filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

§ 2698.604. Excess State Liability in the Pilot Program.

(a) The Board shall determine at least semiannually at a public meeting of the Board, the viability of the Major Risk Medical Insurance Fund, or other funding sources made available to the Board to make interim semiannual or final annual payments to Pilot Program health plans.

(b) If the Board determines that funds for the Pilot Program or for payments beyond the term of the Pilot Program are in a state of excess liability, the Board shall notify the Department of Managed Health Care, the Department of Insurance, and all Pilot Program health plans known to the Board, of the state of excess liability, within 30 days of the determination. The notification shall include a determination of the allowable premium rates change that may be charged to program graduates, to the amount the Board would charge without a state subsidy for the applicable standard benefit plan within the Major Risk Medical Insurance Program. Pilot Program health plans shall be allowed to charge these rates, consistent with the policies and procedures for rate increase notifications of the state department (either Department of Managed Health Care or Department of Insurance) which regulates the Pilot Program health plan.

NOTE: Authority cited: Section 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 10127.16, 12711 and 12712, Insurance Code.

HISTORY

1. New section filed 8–4–2003 as an emergency; operative 8–4–2003 (Register 2003, No. 32). Amendments to remain in effect for 180 days pursuant to section 21, chapter 794, Statutes of 2002 (AB 1401). A Certificate of Compliance must be transmitted to OAL by 2–2–2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–4–2003 order transmitted to OAL 1–23–2004 and filed 3–1–2004 (Register 2004, No. 10).

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Title 10. Investment

Chapter 5.6. Access for Infants and Mothers Program

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Chapter 5.6. Access for Infants and Mothers Program

Article 1. Definitions

§ 2699.100. Definitions.

(a) "Appellant" means an applicant or subscriber who has filed an appeal with the program.

(b) "Applicant" means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. "Applicant" also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent or stepparent.

(c) "Application Date" means the date an application is sent to the program as evidenced by the U.S. postmark date on the application envelope, or documentation from other delivery services including fax delivery.

(d) "Board" means the Managed Risk Medical Insurance Board.

(e) "Coverage" means the payment for benefits provided through the program.

(f) "Disenroll" means to terminate coverage by the program.

(g) "Eligible" means the applicant is qualified to be enrolled in a participating health plan.

(h) "Enroll" means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant.

(i) "Executive Director" means the executive director for the Board.

(j) "Family member" means the following persons living in the individual's home:

(1) Children under age 21, of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.

(3) The stepparents of the sibling children.

(4) The separate children of either an unmarried parent or a married parent or stepparent.

(5) An unborn child of the pregnant woman who is applying for coverage on her own behalf or on whose behalf an application has been submitted.

(6) Children under the age of 21, of married or unmarried parents, away at school who are claimed as tax dependents.

(7) The spouse of the pregnant woman.

(k) "Federal poverty level" means the level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(*l*) "Gross household income" means the total annual gross income of all family members except dependent children. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, self–employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability worker's compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes child support, public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

(m) "Healthy Families Program" (HFP) means the Federal/State funded program that is operated pursuant to Title XXI of the Social Security Act and Part 6.2 (commencing with Section 12693) of Division 2 of the California Insurance Code, and that provides low cost health, dental and vision insurance coverage to eligible children.

(n) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member except dependent children working or receiving disability workers' compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and disabled dependent care expenses of up to $175 for a disabled dependent living in the home.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) $50 for alimony payments received by the pregnant woman. If a woman receives less than $50, the deduction can only be for the amount received.

(o) "Infant" means a subscriber's child born to a subscriber while the subscriber is enrolled in the program.

(p) "Living in the home" means using the home as the primary place of residence.

(p) "Medi–Cal" means the California health care services program under Title XIX of the Social Security Act.

(r) "Medicare" means the Health Insurance for the aged and permanently disabled provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

(s) "Participating health plan" means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(3) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(4) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(5) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

(6) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

(t) "Program" means the Access for Infants and Mothers Program.

(u) "Resident" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.

(v) "State supported services" mean abortion services provided to the subscribers through the program.

(w) "Subscriber" means an individual who is eligible for and enrolled in the program.

(x) "Subscriber contribution" means the cost to the subscriber to participate in the program.

(y) "Tenses and Number". The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

(z) "Time." Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696 and 12698, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order including amendment of subsections (j), (k)(1), (k)(4) and (p) transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Change without regulatory effect amending subsection (j) filed 4–5–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 15).
4. Amendment of subsections (c) and (j) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).
6. Change without regulatory effect amending subsection (j) filed 4–25–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 17).
7. Change without regulatory effect amending subsection (j) filed 5–14–96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 20).
8. Change without regulatory effect amending subsection (j) filed 4–28–97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 18).
9. Change without regulatory effect amending subsection (j) filed 5–10–99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 20).
10. Repealer and new subsection (j), new subsections (*l*) and (n)–(n)(4), subsection relettering, and amendment of newly designated subsection (m) filed 3–17–2000 as an emergency; operative 3–17–2000 (Register 2000, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–17–2000 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 3–17–2000 order transmitted to OAL 6–12–2000 and filed 7–10–2000 (Register 2000, No. 28).
12. Change without regulatory effect amending subsections (*l*) and (x) filed 5–23–2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 21).
13. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).
14. New subsections (j)(7) and (m) and subsection relettering filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
15. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
16. New subsection (v) and subsection relettering filed 3–12–2008; operative 4–11–2008 (Register 2008, No. 11).

Article 2. Eligibility, Application, and Enrollment

§ 2699.200. Basis of Eligibility.

(a) All eligibility requirements contained herein shall be applied without regard to race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.

(b) To be eligible for the program, an individual shall meet the requirements of either (1) or (2):

(1) Meet all of the following requirements:

(A) Be certified as pregnant by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, nurse midwife, vocational nurse, or medical assistant, and have a reasonable good faith belief that the pregnancy is not beyond the 30th week of gestation as of the application date; and

(B) Be a resident of the state of California and have been a resident for at least six continuous months immediately prior to the date of signing the application; and

(C) Have a monthly household income after income deductions that is above 200 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level at the time of application; and

(D) Pay the first portion of the subscriber contribution, which shall be fifty dollars ($50), and agree to the payment of the complete subscriber contribution; and

(E) Not be reimbursed by any health care provider or any state or local governmental entity for payment of the subscriber contribution and not have any health care provider or state or local governmental entity pay the subscriber contribution; and

(F) Not be a beneficiary of either no–cost Medi–Cal or Medicare Part A and Part B as of the application date; and

(G) Not be covered for maternity benefits in a private insurance arrangement as of the application date. A pregnant woman in a private insurance arrangement with a separate maternity only deductible or copayment greater than $500 shall be deemed not covered for maternity benefits for purposes of determining eligibility.

(2) Be an infant of less than two (2) years of age born to a program subscriber who was enrolled prior to July 1, 2004, and reside in California.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05, 12698, 12698.05 and 12698.06, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsection (b)(1)(E) filed 6–8–92 as an emergency; operative 6–8–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–6–92 or emergency language will be repealed by operation of law on the following day.
4. Amendment of subsection (b)(1)(G) filed 10–28–92 as an emergency; operative 10–28–92 (Register 92, No. 44). A Certificate of Compliance must be transmitted to OAL 3–1–93 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–8–92 order transmitted to OAL 9–24–92 and filed 11–5–92 (Register 92, No. 45).
6. Certificate of Compliance as to 10–28–92 order transmitted to OAL 2–9–93 and filed 3–24–93 (Register 93, No. 13).
7. Amendment of subsection (b)(1)(C) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).
9. Amendment of subsections (b)(1)(C) and (b)(1)(E) filed 8–29–95 as an emergency; operative 8–29–95 (Register 95, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–27–95 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8–29–95 order transmitted to OAL 12–11–95 and filed 1–22–96 (Register 96, No. 4).
11. Amendment of subsections (b)(1)(C) and (b)(1)(G) filed 3–17–2000 as an emergency; operative 3–17–2000 (Register 2000, No. 11). A Certificate of Compliance must be transmitted to OAL by 7–17–2000 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 3–17–2000 order transmitted to OAL 6–12–2000 and filed 7–10–2000 (Register 2000, No. 28).
13. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).
14. Amendment of subsection (b)(2) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
15. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.201. Application.

(a) To apply for the program an individual shall submit:

(1) All information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this section; and

(2) A cashier's check or money order for fifty dollars ($50.00); and

(3) A statement signed by the applicant agreeing that if the pregnant woman is enrolled, the applicant will pay the full subscriber contribution

and acknowledging that the program will take aggressive action to collect the full subscriber contribution.

(b) The applicant shall sign and date a declaration stating that the information is true and accurate to the best of his or her knowledge.

(c) The applicant will be notified in writing that the application is incomplete and what documentation is required for completion.

(d)(1) The application, entitled Access for Infants and Mothers (AIM) Application (rev 6/04), which is incorporated by reference, shall contain the following:

(A) The pregnant woman's full name,

(B) The pregnant woman's current living address including house or building number (and unit number if applicable), street, city, county, state, and zip code, and phone number,

(C) The pregnant woman's date of birth,

(D) The pregnant woman's social security number (provision of the Social Security number is not mandatory),

(E) The pregnant woman's ethnicity and primary language (not mandatory),

(F) Certification by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, nurse midwife, vocational nurse, or medical assistant, that the woman on whose behalf the application is filed is pregnant,

(G) The first day of the pregnant woman's last menstrual period,

(H) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, beyond the 30th week of gestation in a current pregnancy, as of the application date,

(I) Information about whether the applicant or anyone in the household smokes,

(J) The address to which the bills for the subscriber's contribution are to be sent, if different from the current living address,

(K) A list of all family members living in the home, their ages, and relationship to the pregnant woman,

(L) A list of those family members, and their social security numbers excluding dependent children, living in the home who had income in the previous or current calendar year, (provision of the social security number is not mandatory),

(M) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed in (L) above, provide documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:

a. Federal tax return. If self-employed, a schedule C must be included.

b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

2. For the current calendar year:

a. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

i. The employee's name.

ii. The employer's business name, business address and phone number.

iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

b. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

c. If self-employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, "the information provided is true and correct."

d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.100, and

iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

(N) The name of each family member living in the home who pays court ordered child support or court ordered alimony. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of alimony paid, child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

(O) A declaration that the pregnant woman is not a beneficiary of either no-cost Medi-Cal or Part A and Part B of Medicare,

(P) A declaration that the pregnant woman has been a resident of the State of California for six (6) continuous months immediately prior to the date of the signing of the application,

(Q) A declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the pregnant woman is enrolled,

(R) Information about any health coverage that is in effect for the pregnant woman or will be in effect for the infant, including the name, address, and policy number of the current insurance or health plan,

(S) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, covered for maternity benefits in a private insurance arrangement. A pregnant woman with a separate, maternity only deductible or co-payment greater than $500 shall be deemed not covered for maternity benefits for purposes of this declaration,

(T) Name and address of the primary employer of each adult family member who is employed,

(U) Information about health coverage available to the applicant, spouse, or father of the baby who is in the household,

(V) A declaration that the applicant has reviewed the benefits offered by the participating health plans,

(W) A declaration that the applicant understands and will follow the rules and regulations of the program,

(X) A declaration that the applicant is giving permission for the program to verify family income, health insurance, residence, and other circumstances,

(Y) A declaration that the subscriber is not being, and will not be, reimbursed by any health care provider or any state and local governmental entity for payment of the subscriber contribution and that no health care provider or state or local governmental entity is paying or will pay the subscriber contribution,

(Z) An indication of the pregnant woman's first choice and second choice participating health plans,

(AA) A declaration that the subscriber agrees to pay the required subscriber contribution, even if the subscriber does not take full advantage of the coverage or services.

(BB) A declaration that the information and documentation submitted is true and correct to the best of the applicant's knowledge.

(2) The Social Security number and other personal information are needed for identification and administrative purposes.

(3) If applicable, the applicant's signed authorization to forward the application to the Medi-Cal Program in the county in which the applicant resides for a determination of eligibility for no-cost Medi-Cal.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12698 and 12698.05, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).
3. Amendment of subsection (d)(1)(W) filed 6-8-92 as an emergency; operative 6-8-92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10-6-92 or emergency language will be repealed by operation of law on the following day.
4. Amendment of subsection (d)(1)(Q) filed 10-28-92 as an emergency; operative 10-28-92 (Register 92, No. 44). A Certificate of Compliance must be transmitted to OAL 3-1-93 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6-8-92 order transmitted to OAL 9-24-92 and filed 11-5-92 (Register 92, No. 45).
6. Certificate of Compliance as to 10-28-92 order transmitted to OAL 2-9-93 and filed 3-24-93 (Register 93, No. 13).
7. Amendment of subsections (d)(1), (d)(1)(L) and (d)(1)(L)4 and new subsection (d)(1)(Y) filed 8-29-94 as an emergency; operative 9-1-94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12-30-94 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 8-29-94 order, including amendment of subsection (d)(1)(L), transmitted to OAL 12-9-94 and filed 1-23-95 (Register 95, No. 4).
9. Amendment of subsections (a)(1)-(2) and (d)(1) filed 8-29-95 as an emergency; operative 8-29-95 (Register 95, No. 35). A Certificate of Compliance must be transmitted to OAL by 12-27-95 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8-29-95 order including amendment of (d)(1)(F) transmitted to OAL 12-11-95 and filed 1-22-96 (Register 96, No. 4).
11. Amendment of subsections (d)(1), (d)(1)(L) and (d)(1)(L)3. and new subsections (d)(1)(L)3.a-f. filed 8-9-96 as an emergency; operative 8-9-96 (Register 96, No. 32). A Certificate of Compliance must be transmitted to OAL by 12-9-96 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 8-9-96 order, including amendment of subsection (d)(1)(k), transmitted to OAL 11-19-96 and filed 1-6-97 (Register 97, No. 2).
13. Amendment of subsections (d)-(d)(2) filed 3-17-2000 as an emergency; operative 3-17-2000 (Register 2000, No. 11). A Certificate of Compliance must be transmitted to OAL by 7-17-2000 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 3-17-2000 order, including further amendment of subsections (d)(1)(M)2.a.i.(iv). and (d)(1)(M)2.a.ii., transmitted to OAL 6-12-2000 and filed 7-10-2000 (Register 2000, No. 28).
15. Amendment filed 5-20-2003; operative 5-20-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).
16. Amendment of subsections (d)(1) and (d)(1)(M)-(N) filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 7-1-2004 order, including further amendment of subsection (d)(1), transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).

§ 2699.202. Initial Review of Application.

Upon receipt of an application the program shall determine if there is funding available for additional enrollment in the program.

(a) If there is no funding available the application shall be rejected and returned.

(b) If there is funding available the application shall be reviewed for completeness.

(1) If it is not complete a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a letter will be mailed to the applicant indicating the required information and/or documentation needed to complete the application. The applicant must provide all information and/or documentation necessary for the application to be completed within 17 calendar days from the date the application was received by the program and prior to the 30th week of gestation, and the applicant will be so notified.

(2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days and prior to the 30th week of gestation, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.

(3) If it is complete it will be reviewed for an eligibility determination pursuant to Section 2699.203.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05 and 12696.15, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).
3. Amendment of subsection (b)(1), new subsection (b)(2) and subsection renumbering filed 5-20-2003; operative 5-20-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.203. Determination of Eligibility.

(a) The program shall determine the applicant's eligibility based upon the criteria specified in Section 2699.200. The program shall complete the application review process within 10 calendar days of receipt of the complete application.

(b) Applicants determined ineligible shall be notified in writing by the program. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The first portion of the applicant's subscriber contribution shall be refunded.

(c) Applicants determined eligible shall be enrolled.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12696.05, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).

§ 2699.204. Enrollment.

(a) Applicants determined eligible for the program shall be enrolled in their:

(1) First choice participating health plan, unless that plan is currently serving the number of subscribers which it has contracted with the program to serve.

(2) Second choice participating health plan when the first choice plan is currently serving the number of subscribers which it has contracted with the program to serve.

(b) An applicant shall be notified in writing by the program of enrollment with a participating health plan and the beginning date of coverage by the participating health plan.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12696.05, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).

§ 2699.205. Registration of Infants.

(a) For infants born to subscribers who are enrolled prior to July 1, 2004, the subscriber shall register the infant as follows:

(1) Within thirty (30) days of the birth of an infant, the subscriber shall notify her health plan in writing of the following information about the infant:

(A) Name; and

(B) Date of birth; and

(C) Sex; and

(D) Weight at birth.

(2) Within thirty (30) days prior to an infant's first birthday, the subscriber shall notify the program in writing if the subscriber wishes to disenroll the infant from the program. If notification is not received, the child is automatically enrolled for the second year.

(b) For infants born to subscribers who are enrolled on or after July 1, 2004, the subscriber shall register the infant in the Healthy Families Program as follows:

(1) Upon the birth of the infant, the subscriber shall provide to the Healthy Families Program the required premium and provide the following information about the infant:

(A) Name; and

(B) Date of birth; and

(C) Sex; and

(D) For infants born on or after July 1, 2007:

1. Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and

2. Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reason for termination.

(2) The Healthy Families Program shall request the infant's birth weight and primary care provider from the subscriber.

(3) Subject to all requirements specified in the statute and regulations governing the Healthy Families Program, the infant will be enrolled in the Healthy Families Program with coverage effective on the date of the infant's birth.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12693.765 and 12696, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order including amendment of subsection (b) transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsection (a) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).
5. Amendment of subsection (b) filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).
6. Amendment of section heading, section and NOTE filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
8. Amendment of subsections (b)(1) and (b)(1)(C) and new subsections (b)(1)(D)–(b)(1)(D)2. deemed an emergency and exempt from OAL review pursuant to Section 75 of Chapter 74, Statutes of 2006, filed 7–31–2007; operative 7–31–2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–2008 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 7–31–2007 order transmitted to OAL 1–28–2008 and filed 3–12–2008; (Register 2008, No. 11).

§ 2699.206. Change of Address and/or Phone Number.

An applicant shall notify the program in writing within thirty (30) days of any change of the applicant's billing address or any change of residence or phone number of a person participating in the program.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of section heading and section filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.207. Disenrollment.

(a) A subscriber and/or infant shall be disenrolled from the program and from the program's participating health plan when any of the following occur:

(1) The subscriber so requests in writing.

(2) The subscriber becomes ineligible because:

(A) The subscriber fails to meet the residency requirement; or

(B) The subscriber has committed an act of fraud to circumvent the statutes or regulations of the program,

(C) The subscriber is no longer pregnant on her effective date of coverage. If notification to the program is received after the effective date, documentation by a licensed or certified healthcare professional must be submitted indicating the date of the miscarriage.

(3) The infant becomes ineligible because the infant fails to meet the residency requirement.

(b) A subscriber shall be notified by the program in writing of the disenrollment of the subscriber and/or infant from the program, the effective date, and the reason for the disenrollment.

(c) Except for Section 2699.207(a)(2)(C), disenrollment shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the applicant. Disenrollment pursuant to Section 2699.207(a)(2)(C) shall take effect upon the date that would have been the effective date of coverage.

(d) Once a subscriber and/or infant is disenrolled pursuant to Section 2699.207(a), the subscriber and/or infant cannot be re–enrolled for the same pregnancy.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. New subsections (a)(2)(C) and (d) and amendment of subsection (c) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).
5. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.208. Continuation of Benefits.

Infants shall be eligible to continue coverage in the program from a participating health plan if the subscriber is deceased or becomes ineligible for reasons other than an act of fraud while the infant is otherwise eligible.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).

§ 2699.209. Coverage.

(a) The date on which the coverage shall begin shall be no later than ten (10) calendar days from the date the applicant is enrolled. Coverage shall not begin if the pregnancy terminates prior to the effective date of coverage.

(b) Coverage in the program for the subscriber shall be for one pregnancy and shall include services following the pregnancy for sixty (60) days. The subscriber shall be notified of the date her coverage ends and such notice will be provided at least twenty (20) days prior to that date.

(c) Coverage in the program for an infant born to a subscriber who is enrolled prior to July 1, 2004 shall be for two (2) years from the date of the birth of the child.

(d) Notwithstanding subsections (b) and (c) above coverage in the program for either the subscriber or the infant will cease at disenrollment.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsection (a) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).
5. Amendment of subsection (c) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.210. Transfer of Enrollment.

(a) A subscriber and/or infant, if any, shall be transferred from one participating health plan to another if any of the following occurs:

(1) A subscriber so requests, in writing, because the subscriber and/or infant, if any, has moved and no longer resides in an area served by the participating health plan in which the subscriber and/or infant, if any, is enrolled, and there is at least one participating health plan serving the area in which the subscriber and/or infant now resides that is accepting new enrollees.

(2) The subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber–plan relationship and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating health plan serving the area in which the subscriber resides that is accepting new enrollees.

(3) The program contract with the participating health plan in which the subscriber is enrolled is canceled or not renewed.

(b) The effective date of transfers pursuant to subsection (a)(1) of this section shall be:

(1) On the first day of a month following the transfer request for an infant, if the request is received on or before the 10th of the month. Transfer of enrollment shall take effect on the first day of the second month following the transfer request for an infant, if the request is received after the 10th of the month.

(2) Within seventeen (17) calendar days of receipt of the transfer request for the subscriber.

(c) The effective date of transfers pursuant to subsection (a)(2) of this section shall be:

(1) On the first day of a month following the approval of the transfer request for an infant, if the approval is made on or before the 10th of the month. Transfer of enrollment shall take effect on the first day of the second month following the approval of the transfer request for an infant, if the approval is made after the 10th of the month.

(2) Within fifteen (15) calendar days from approval of the transfer request for the subscriber.

(d) The effective date of transfers pursuant to subsection (a)(3) of this section shall be prior to the end of the contract.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12697.10, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.211. Payment for Application Assistance.

(a) The program shall pay an insurance agent as defined in Section 31 of the Insurance Code, or broker as defined in Section 33 of the Insurance Code, or a licensed general acute care hospital, or a licensed medical doctor, or a licensed doctor of osteopathy, or a registered nurse, or a county health department, or a county welfare department, or a licensed day care operator, or a licensed primary care community clinic, or a direct state maternal and child health contractor, or a participating health plan, or a licensed chiropractor for assisting an individual in completing the application form, if the following conditions are met:

(1) The individual is enrolled as a result of the application; and

(2) The request for payment is made in writing and specifies to whom the payment shall be made; and

(3) Such request accompanies the application and includes the name, position/title and address and, if applicable, the license number of the person who assists in the completion of the application and the tax identification number of the person/entity to be paid. An incomplete request will be rejected; information missing from the application cannot be submitted at a later date.

(b) The amount of such payment shall be fifty dollars ($50.00).

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsections (a) and (a)(3) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).

Article 3. Scope of Benefits

§ 2699.300. Minimum Scope of Benefits.

(a) The basic scope of benefits offered by participating health plans to subscribers and infants must comply with all requirements of the Knox–Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.301. No other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic scope of benefits shall be as follows:

(1) Health Facilities

(A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x–ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy, respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

(B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes physical, occupational, and speech therapy as appropriate; and those hospital services, which can reasonably be provided on an ambulatory basis. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

(2) Durable medical equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non–insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

(3) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital, which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through "911" emergency response system.

Non–emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when:

(A) medically necessary, and

(B) requested by a plan provider, and

(C) authorized in advance by the participating health plan

Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

(4) Emergency Health Care Services: Twenty–four hour emergency care for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the patient's health in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

This must be provided both in and out of the health plan service area and in and out of the health plan's participating facilities.

(5) Professional Services: Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

(A) Eye Examinations: Eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.

(B) Hearing tests, hearing aids and services: Hearing tests, hearing aids and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one–year period following the provision of a covered hearing aid.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered one–year warranty period, replacement of a hearing aid more than once in any period of thirty–six months, and surgically implanted hearing devices.

(C) Immunizations for infants: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians. Immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for Subscribers: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

(D) Periodic health examinations for infants: periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the current version of the Recommended Childhood Immunization Schedule/United States, adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the infant including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for Subscribers: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations.

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(E) Well baby care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

(6) Health education services: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan. Health education services include services related to tobacco use and drug and alcohol abuse.

Health education services relating to tobacco use means tobacco use prevention and education services including tobacco use cessation services.

(7) Nutrition Services: Direct patient care nutrition services, including nutritional assessment.

(8) Prescription Drugs: Medically necessary prescription drugs, when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin depen-

dent, non–insulin dependent and gestational diabetes. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins, if such vitamins require a prescription. Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy. Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Contraceptive Drugs and Devices: All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over–the–counter medicines, including non–prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), and appetite suppressants or any other diet drugs or medications.

(9) Reconstructive Surgery: Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do any of the following:

(A) To improve function

(B) To create a normal appearance to the extent possible

(C) To restore and achieve symmetry incident to mastectomy. Services for this purpose include reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury, and breast prosthesis required incidental to the surgery.

(10) Transplants:

Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants. Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

(11) Maternity Care: Medically necessary professional and hospital services relating to maternity care including: pre–natal and post–natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

(12) Family Planning: Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

(13) Diagnostic X–ray and laboratory Services: Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow–up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro–encephalography, prenatal diagnosis of genetic disorders of the fetus in cases of high–risk pregnancy, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A–1C (Glycohemoglobin).

(14) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy); and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost–effective when there is a choice among several medically appropriate alternative services or settings. Exclusions: Custodial care

(15) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.

(16) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

(17) Cataract Spectacles and Lenses: Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.

(18) Skilled Nursing: Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24–hour per day basis; bed and board; x–ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

(19) Hospice: The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include physical therapy; occupational therapy, speech therapy, short–term inpatient care, pain control and symptom management. The hospice benefit may include, at the option of the health plan, homemaker services; services of volunteers, and short–term inpatient respite care. The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

(20) Orthotics and Prosthetics: Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non–rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts;

dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

(21) Mental Health:

(A) Inpatient: Plans must provide services with no visit limits for severe mental illnesses including Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic–depressive illness), major depressive disorders, panic disorder, obsessive–compulsive disorder, pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa, and services for serious emotional disturbances in children. Plans must provide coverage for up to 30 days per benefit year for illnesses that do not meet the criteria for severe mental illnesses, and for conditions that do not meet the criteria for serious emotional disturbances of a child.

Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

(B) Outpatient: Plans must provide services with no visit limits for severe mental illnesses including Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic–depressive illness), major depressive disorders, panic disorder, obsessive–compulsive disorder, pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa, and services for serious emotional disturbances in children.

Plans must provide up to 20 visits per benefit year for illnesses that do not meet the criteria for severe mental illness or serious emotional disturbances of a child. Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.

(22) Alcohol and Drug Abuse:

(A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Participating health plans shall offer at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.

(b) This part shall not be construed to prohibit a plan's ability to impose cost–control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order including amendment of subsections (a)(1) and (a)(10)(D) transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.301. Excluded Benefits.

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

(1) Services which are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage, except as provided in Section 2699.303.

(3) Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self–administered.

(4) Personal or comfort items, or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:

(A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(B) Outmoded or not efficacious.

(7) Transportation except as specified in Section 2699.300(a)(3).

(8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in Section 2699.300(a)(9)(C).

(9) Eyeglasses, except those eyeglasses or contact lenses necessary after cataract surgery, which are covered under Subsection 2699.300(a)(17).

(10) Long–term care benefits including long–term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short–term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.300(a)(18) and (19).

(11) Dental services, including dental treatment for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible. This language shall not be construed to exclude surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.

(12) Cosmetic surgery, including treatment for complications of cosmetic surgery, that is solely performed to alter or reshape normal structures of the body in order to improve appearance, except as specifically provided in Section 2699.300(a)(9).

(13) Any services or items specified as excluded within Section 2699.300.

(14) Any benefits in excess of limits specified in Section 2699.300.

(15) Treatment for infertility is excluded. Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

(16) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which such benefits are provided or payable under any Worker's Compensation benefit plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

(17) Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.302. Pre–Existing Conditions Exclusion and Postenrollment Waiting Period.

Subscribers and infants shall not be subject to any pre–existing condition exclusion period or postenrollment waiting period.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).

§ 2699.303. Services Received Prior to Enrollment.

(a) Subscribers may be reimbursed up to a total of one hundred and twenty–five dollars ($125.00) for pregnancy–related medically necessary services, including but not limited to pregnancy test and initial prenatal visit, received in the time period beginning forty (40) calendar days prior to the application date that a complete application is received by the program and ending on the beginning date of coverage.

(b) Requests for payment pursuant to this section shall be submitted by the subscriber within ninety (90) calendar days of the date service was provided and shall include the following information:

(1) An original bill which includes the name and business address of the medical doctor, doctor of osteopathy, registered nurse, pharmacist or physician's assistant, or laboratory providing the service,

(2) Name, address, date of birth and social security number (not mandatory) of the subscriber for whom services were provided,

(3) Date service was provided,

(4) Type of service provided,

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12698.25, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsections (b)–(b)(1) and repealer of subsection (b)(5) filed 8–29–94 as an emergency; operative 9–1–94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–30–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–29–94 order transmitted to OAL 12–9–94 and filed 1–23–95 (Register 95, No. 4).
5. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

§ 2699.304. Order of Benefit Determination.

The coverage of this program shall not duplicate and shall pay secondary to any other valid and collectible medical coverage, except Medi–Cal.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12698.06, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment filed 5–20–2003; operative 5–20–2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).

Article 4. Subscriber Contributions and Payment for Services

§ 2699.400. Subscriber Contributions.

(a) Subscriber contributions shall be:

(1) An initial fifty dollars ($50.00) to be submitted with the application, and

(2) For subscribers who are enrolled prior to July 1, 2004, the difference between two per cent (2%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment; and

(3) For infants born to subscribers who are enrolled prior to July 1, 2004, one hundred dollars ($100.00) which shall be due on the infant's first birthday unless either of following apply:

(A) The infant is disenrolled from the program prior to the infant's first birthday, or

(B) The subscriber provides written proof that the infant is current for the infant's first year immunizations. Such immunizations shall be consistent with the most current version of the Recommended Childhood Immunization Schedule jointly adopted by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. The written proof of completed current first year immunizations shall be signed by a licensed medical doctor, licensed doctor of osteopathy, registered nurse, or licensed physician's assistant. When such written notice is provided the amount shall be fifty dollars ($50.00).

(4) For subscribers who are enrolled on or after July 1, 2004, the difference between one and one–half percent (1.5%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment.

(b) There shall be no penalty for early payment of any portion of the subscriber contribution.

(c) In cases of multiple births to a subscriber, the $100 payment shall apply to each infant born to a subscriber who is enrolled prior to July 1, 2004.

(d) Subscribers shall not be reimbursed by any health care provider or state or local governmental entity for payment of the subscriber contribution and shall not have any health care provider or state or local governmental entity pay the subscriber contribution.

(e) No portion of the subscriber contribution is refundable except as provided in Sections 2699.202 and 2699.203 or unless the subscriber is disenrolled pursuant to Subsection 2699.207(a)(2)(C).

(f) A federally recognized California Indian Tribal Government may make required subscriber and infant contributions on behalf of a member of the tribe.

(g) An applicant in arrears of subscriber contributions shall be sent a reminder notice. Applicants who become ninety (90) days in arrears on subscriber contributions will be reported to a credit reporting agency. If accounts are paid in full at a later date, the credit reporting agency's records shall be updated.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05 and 12698, Insurance Code.

HISTORY

1. New article 4 and section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order including amendment of subsection (a)(3)(B) transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsection (c) filed 6–8–92 as an emergency; operative 6–8–92 (Register 92, No. 24). A Certificate of Compliance must be transmitted to OAL 10–6–92 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 6-8-92 order transmitted to OAL 9-24-92 and filed 11-5-92 (Register 92, No. 45).
5. Amendment of subsection (a)(3)(A), new subsection (c) and subsection redesignation, and amendment of subsection (e) filed 8-29-94 as an emergency; operative 9-1-94 (Register 94, No. 35). A Certificate of Compliance must be transmitted to OAL by 12-30-94 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction inserting article heading and amending HISTORY 1 (Register 94, No. 35).
7. Certificate of Compliance as to 8-29-94 order transmitted to OAL 12-9-94 and filed 1-23-95 (Register 95, No. 4).
8. Amendment of subsection (a)(2) filed 3-17-2000 as an emergency; operative 3-17-2000 (Register 2000, No. 11). A Certificate of Compliance must be transmitted to OAL by 7-17-2000 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 3-17-2000 order transmitted to OAL 6-12-2000 and filed 7-10-2000 (Register 2000, No. 28).
10. Amendment of subsections (a)(2) and (a)(3)(B) and new subsections (f) and (g) filed 5-20-2003; operative 5-20-2003 pursuant to Government Code section 11343.4 (Register 2003, No. 21).
11. Amendment of subsections (a)(2)-(3), new subsection (a)(4) and amendment of subsection (c) filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 7-1-2004 order transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).
13. Amendment of article heading filed 3-12-2008; operative 4-11-2008 (Register 2008, No. 11).

§ 2699.401. Discount for Prepayment of Subscriber Contribution.

The subscriber contribution amount shall be reduced by fifty dollars ($50) if the subscriber submits the total annual subscriber contribution amount described in Section 2699.400(a)(2) and Section 2699.400(a)(4), with her application.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).
3. Repealer and new section filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7-1-2004 order transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).

§ 2699.402. Payment of State Supported Services.

State supported services shall be paid for by State dollars only. No Federal dollars provided to the State pursuant to Title XXI of the Social Security Act shall be used.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code; and 42 CFR Section 457.475.

HISTORY

1. New section filed 3-12-2008; operative 4-11-2008 (Register 2008, No. 11).

Article 5. Appeals

§ 2699.500. Appeals to the Board.

(a) If a subscriber is dissatisfied with any action or failure to act which has occurred in connection with a participating health plan's coverage the subscriber's remedy shall be to file an appeal with the Board.

(b) In addition, the following decisions may be appealed to the Executive Director only:

(1) A program determination as to eligibility of any applicant.

(2) A program determination to disenroll a subscriber or infant from the program.

(3) A program determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).
3. Amendment of subsection (b) filed 1-10-95 as an emergency; operative 1-10-95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5-10-95 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of Reference cite (Register 95, No. 13).
5. Certificate of Compliance as to 1-10-95 order transmitted to OAL 4-25-95 and filed 6-7-95 (Register 95, No. 23).

§ 2699.501. Dispute Resolution.

Notwithstanding other sections in this Article, when a subscriber is dissatisfied with any action, or inaction, of the program's participating health plan in which she is enrolled, the subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).

§ 2699.502. Filing an Appeal.

(a) An appeal shall be filed in writing with the Executive Director within sixty (60) calendar days of the action or failure to act or receipt of notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed; or a written statement of the action or failure to act being appealed;

(2) A statement specifically describing the issues which are disputed by the appellant;

(3) A statement of the resolution requested by the appellant; and

(4) Any other relevant information the appellant wants to include.

(c) Any appeal that does not include all necessary information shall be returned to the applicant or subscriber without review. The applicant or subscriber may re-submit the appeal. The resubmittal shall be filed within the time limits of subsection (a) or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

HISTORY

1. New section filed 12-12-91 as an emergency; operative 12-12-91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4-10-92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-12-91 order transmitted to OAL 4-8-92 and filed 5-20-92 (Register 92, No. 21).
3. Repealer of subsections (c)-(c)(2) and subsection relettering filed 1-10-95 as an emergency; operative 1-10-95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5-10-95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1-10-95 order transmitted to OAL 4-25-95 and filed 6-7-95 (Register 95, No. 23).

§ 2699.503. Administrative Review.

(a) Any appeal filed pursuant to this Article will be given an administrative review.

(b) Administrative reviews of appeals shall be conducted by the Executive Director.

(c) In conducting an administrative review of an appeal, the Executive Director may contact the appellant and/or the participating health plan for further information.

(d) The Executive Director's decision shall be in writing.

(e) If an appeal was filed pursuant to section 2699.500(a), the appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the Executive Director. Such a request shall

be filed within thirty (30) calendar days of receipt of the Executive Director's decision. It shall include a clear and concise statement of what action is being appealed, and the reason(s) the Executive Director's decision is not correct.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsections (a) and (e) filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

§ 2699.504. Hearings.

When an appeal which requests an administrative hearing is received, the appeal shall be set for hearing as follows:

(a) Administrative hearings of appeals will be conducted according to the appeal procedures, including pre– and post–hearing procedures, set forth in Chapter 2.5, adopted (commencing with section 251) of Division 2 of Title 1 of the California Code of Regulations. Chapter 2.5, as adopted on June 4, 1984, is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private non–profit human service organization shall be deemed reference to the petitioner.

(3) Reference to the grievance procedure established in accordance with Health and Safety Code section 38036 shall be deemed reference to the administrative review process set forth in section 2699.503.

(4) Reference to Health and Safety Code sections providing the bases, grounds, authorization or procedures for appeals shall be deemed reference to the bases and authorization for appeal found in section 2699.500, and the appeal procedures found in this section.

(5) The 30–day time period specified in section 251(b) shall be extended to 60 days, and the 10–day time period in section 252(a) shall be extended to 30 days.

(6) If the proposed decision submitted to the Board is not adopted as the decision, the Board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(7) The decision of the Board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

(b) The Board may elect to have a hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Amendment of subsection (a) and new subsections (a)(1)–(a)(7) filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

§ 2699.505. Conduct of Hearing by Hearing Officer.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order including amendment of subsection (b) transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Repealer filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

§ 2699.506. Decision on Appeal Hearing by Hearing Officer.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12698.20, Insurance Code.

HISTORY

1. New section filed 12–12–91 as an emergency; operative 12–12–91 (Register 92, No. 10). A Certificate of Compliance must be transmitted to OAL 4–10–92 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–12–91 order transmitted to OAL 4–8–92 and filed 5–20–92 (Register 92, No. 21).
3. Repealer filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

* * *

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Title 10. Investment

Chapter 5.7. Voluntary Alliance Uniting Employers Purchasing Pool (The Health Insurance Plan of California)

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Chapter 5.7. Voluntary Alliance Uniting Employers Purchasing Pool (The Health Insurance Plan of California)

§ 2699.610. Definitions.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New chapter 5.7 (sections 2699.610–2699.655), article 1 and section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including relocation of article heading, renumbering and amending former section 2699.610 to section 2699.6000 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).
5. Amendment of Chapter 5.7 heading filed 5–22–95; operative 5–22–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 21).

§ 2699.620. Non–Discrimination.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New article 2 and section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Relocation of article heading and renumbering of former section 2699.620 to section 2699.6100 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.621. Participation Requirements for Sole Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order, including amendment of subsection (b)(4)(A), transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.621 to section 2699.6107 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.621.5. Participation Requirements for Guaranteed Associations.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.621.5 to section 2699.6109 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.621.6. Participation Requirements for Member Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.621.6 to section 2699.6111 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.621.7. Participation Requirements of Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.621.7 to section 2699.6113 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.622. Annual Requalification for Sole Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.622 to section 2699.6117 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.622.5. Annual Requalification for Guaranteed Associations and Guaranteed Association Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.622.5 to section 2699.6119 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.623. Application for Sole Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order, including amendment of subsection (d)(2)(I), transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.623 to section 2699.6121 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.623.5. Application for Guaranteed Association.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.623.5 to section 2699.6123 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.623.6. Member Employer Application.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.623.6 to section 2699.6125 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.623.8. Application for Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.623.8 to section 2699.6127 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.624. Initial Sole Employer Qualification and Sole Employee Enrollment Period.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.624 to section 2699.6131 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.624.5. Initial Qualification for the Program for Guaranteed Associations and Association Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.624.5 to section 2699.6133 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.625. Effective Date of Coverage for Sole Employees.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.625 to section 2699.6159 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.625.5. Effective Date of Coverage for Member Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.625.5 to section 2699.6161 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.625.6. Effective Date of Coverage for Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.625.6 to section 2699.6163 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.626. Participating Employer Disqualification.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–20–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.626 to section 2699.6167 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.626.1. Disqualification of Guaranteed Associations.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.626.1 to section 2699.6169 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.626.15.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.626.15 to section 2699.6171 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.626.2. Disqualification of Member Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.626.2 to section 2699.6173 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.626.3. Disqualification of Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.626.3 to section 2699.6175 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.627. Transfer of Enrollment for Sole and Member Employees.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.627 to section 2699.6187 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.627.5. Transfer of Enrollment for Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.627.5 to section 2699.6189 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.628. Payment to Insurance Agents and Brokers for Sole Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.628 to section 2699.6194 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.628.5. Payment to Insurance Agents and Brokers for Member Employers and Individual Members When Premiums Collected by Guaranteed Association.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.628.5 to section 2699.6195 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.628.6. Payment to Insurance Agents and Brokers for Member Employers When Premium Collected by Program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.628.6 to section 2699.6196 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.628.7. Payment to Insurance Agents and Brokers for Individual Members When Premium Collected by Program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.628.7 to section 2699.6197 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.630. Scope of Benefits.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New article 3 and section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order, including amendment of subsection (a)(2)(B), transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Relocation of article heading and renumbering of former section 2699.630 to section 2699.6200 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.631. Excluded Benefits.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.631 to section 2699.6203 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.632. Administration of Benefits.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.632 to section 2699.6207 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.633. Enrollee Share of Cost.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order, including amendment of subsection (b)(2)(B), transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by

4–28–94 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.633 to section 2699.6209 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.634. Pre–Existing Condition Exclusions.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of subsection (a) filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.634 to section 2699.6213 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.635. Benefit Appeals.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10733, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.635 to section 2699.6217 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.640. Risk Categories.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10746, Insurance Code.

HISTORY

1. New article 4 and section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including relocation of article heading, renumbering and amending former section 2699.640 to section 2699.6300 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.641. Annual Health Benefit Plan Rates.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.641 to section 2699.6303 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.642. Change of Risk Category.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.642 to section 2699.6305 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.643. Program Participation Fee.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering former section 2699.643 to section 2699.6307 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.644. Notification of Rate Changes.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering former section 2699.644 to section 2699.6309 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.645. Premium Payment to Program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10742, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, NO. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering former section 2699.645 to section 2699.6311 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.646. Overdue Payments; Late Fees; Disqualification for Participating Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, NO. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.646 to section 2699.6313 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.646.5. Overdue Payments; Late Fees; Disqualification for Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.646.5 to section 2699.6315 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.650. Appeals to the Board.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. New article 5 and section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including relocation of article heading, renumbering and amending former section 2699.650 to section 2699.6400 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.651. Filing an Appeal.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of subsection (c) filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering former section 2699.651 to section 2699.6401 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.652. Administrative Review.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of subsection (a) filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering former section 2699.652 to section 2699.6403 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.653. Hearings.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.653 to section 2699.6405 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.654. Conduct of Hearing by Hearing Officer.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.654 to section 2699.6407 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.655. Decision By Appeal Hearing by Hearing Officer.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.655 to section 2699.6409 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
4. Editorial correction of printing error (Register 94, No. 23).

Article 1. Definitions

§ 2699.6000. Definitions.

(a) "Benefit year" means the twelve (12) month period commencing July 1 of each year at 12:01 a.m.

(b) "Board" means the Managed Risk Medical Insurance Board.

(c) "Comprehensive individual dental premium" means the individual dental plan rate for an enrolled employee or individual member and enrolled dependents, agent and program participation fees.

(d) "Comprehensive individual medical premium" means the individual medical plan rate for an enrolled employee or individual member and enrolled dependents, agent and program participation fees.

(e) "Dental coverage" means the state of being eligible to receive specified dental benefits under the terms of a dental benefits plan.

(f) "Dental benefit plan" means a policy or a contract written or administered by a participating dental carrier that arranges or provides health care benefits for enrollees.

(g) "Dental benefits premium" means that portion of the employer premium or individual member premium that is owed each month by the participating employer or individual member to the program for coverage of dental benefits. It includes any portion of the participation fee that is for participation in the dental benefits option.

(h) "Dental carrier" means any disability insurance company, health care service plan, specialized health care service plan, or any other entity that writes, issues, or administers group health benefit plans that cover sole employees or guaranteed association members.

(i) "Carrier" means any disability insurance company, health care service plan, nonprofit hospital service plan, or any other entity that writes, issues, or administers group health benefit plans that cover the employees of sole employers or guaranteed association members.

(j) "Coverage" means the state of being eligible to receive specified health benefits under the terms of a health benefit plan.

(k) "Dependent" means a sole employee's or guaranteed association member's spouse and any unmarried dependent child who is an adopted child, a stepchild, or a recognized natural child. A child attains the status of "dependent" at birth or upon legal adoption. A child shall be considered to be adopted upon the sole employee or guaranteed association member receiving physical custody of the child to be adopted. A stepchild attains the status of "dependent" upon the sole employee's or guaranteed association member's marriage to the natural or adopted stepchild's parent. A child ceases to be a "dependent" upon marriage, or attainment of age 23, whichever first occurs; except that an unmarried child who at the time of attaining age 23 is incapable of self–support be-

cause of physical or mental disability which existed continuously from a date prior to attainment of age 23 continues in dependent status until termination of such incapacity.

(*l*) "Disenroll" means termination of coverage in the program for an enrolled sole employee and dependents, if any, or guaranteed association member and dependents, if any.

(m) "Eligible employee" means a sole employee or a member employee. An employee is not an eligible employee until the employee has completed any employer imposed waiting period.

(n) "Employer imposed waiting period" means the period of time an employer requires a new employee to wait before being sponsored for coverage.

(o) "Employer premium" means either:

(1) For participating sole employers who have an effective date of coverage prior to September 1, 1998, who have not made an election pursuant to Section 2699.6116, and participating member employers whose guaranteed association has an effective date of coverage prior to September 1, 1998, and did not make an election pursuant to Section 2699.6116, the dollar amount owed each month by the participating employer to the program. It includes program participation fees, any required late fees, any required reinstatement fees, any required agent, or broker fees, and the sum of individual premiums. It includes the sum of individual premiums for dental benefits if the employer has elected to participate for dental benefits.

(2) For participating sole employers who have an effective date of coverage on or after September 1, 1998, or who have made an election pursuant to Section 2699.6116, and participating member employers whose guaranteed association has an effective date of coverage on or after September 1, 1998, or made an election pursuant to Section 2699.6116, the dollar amount owed each month by the participating employer to the program. It includes the sum of comprehensive individual medical premiums and the sum of comprehensive individual dental premiums if the employer has elected to participate for dental benefits. It includes any required late fees and any required reinstatement fees.

(p) "Enroll" means either:

(1) To accept into the program the eligible employees of a qualified small employer who have applied for coverage and their dependents, or

(2) To accept into the program the qualified individual members of a qualified guaranteed association who have applied for coverage and their dependents.

(q) "Enrollee" means either:

(1) An eligible employee or dependent who receives coverage through the program from a participating carrier, or

(2) A qualified individual member or dependent who receives coverage through the program from a participating carrier.

(r) "Exclusive provider organization" means any disability insurance company or non–profit hospital service plan that limits payments under a policy to services secured by insureds from institutional and professional providers charging alternative rates pursuant to the contract with the insurer.

(s) "Executive Director" means the Executive Director of the Board.

(t) "Fee–for–service dental organization" means dental benefit plans under which retrospective payment is made by a dental carrier on a fee–for–service basis for dental care benefits and services.

(u) "Guaranteed association" means an organization which is a nonprofit organization as determined by the Internal Revenue Service and comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers, (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any health benefits plan that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in a health benefits plan offered to the association provided the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with each carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate. This definition applies regardless of whether a contract issued by a plan is with an association or a trust formed for, or sponsored by, an association to administer benefits for guaranteed association members. For purposes of this definition, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this definition shall be deemed to have been in active existence on January 1, 1992, if its predecessor organization(s) had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this definition.

(v) "Guaranteed association member" means an individual member or member employee of a qualified guaranteed association.

(w) "Health Benefits Plan" means a policy or contract written or administered by a participating carrier that arranges or provides health care benefits for enrollees.

(x) "Health maintenance organization" means either of the following:

(1) Comprehensive group practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(2) Individual practice prepayment plans or network model prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or groups of physicians or other providers of health services who agree to accept the payment provided by the plans as full payment for covered services rendered by them.

(y) "Indemnity plan" means health benefit plans under which retrospective payment is made by a carrier on a fee–for–service basis for health care benefits and services.

(z) "Individual member" means a person who is sponsored for coverage by a qualified guaranteed association and who is not a member employee.

(aa) "Individual member premium" means either:

(1) For individual members whose guaranteed association has an effective date of coverage prior to September 1, 1998, and did not make an election pursuant to Section 2699.6116, the dollar amount owed each month to the program for coverage of an enrolled individual member and an individual member's enrolled dependents. It includes the amount for dental benefits coverage if the individual member's guaranteed association has elected to participate for dental benefits. It includes program participation fees, any required late fees, any required reinstatement fees, and any required agent or broker fees; or

(2) For individual members whose guaranteed association has an effective date of coverage on or after September 1, 1998, or made an election pursuant to Section 2699.6116, the amount owed each month to the program by the individual member. It includes the comprehensive individual medical premium and the comprehensive individual dental premium if the individual member's guaranteed association has elected to participate for dental benefits. In includes any required late fees and any required reinstatement fees.

(bb) "Individual premium" means the dollar amount owed to the program for health or health and dental coverage of an enrolled employee and the employee's enrolled dependents.

(cc) "Late applicant" means either:

(1) An eligible employee or dependent who declined health coverage in the program at the time it was last offered to them by the small employer sponsoring their coverage, and who subsequently applies for enrollment in the program. Otherwise eligible employees or dependents who previously certified to their employer that they had other employer sponsored health coverage or coverage under the federal Medicare program pursuant to Title XVIII of the Social Security Act and waived coverage in the program and who apply for coverage in the program within thirty (30) calendar days of a loss of the other coverage will not be considered to be late applicants; or

(2) An individual member or dependent who did not apply for health coverage at the time it was offered by the guaranteed association and subsequently applies for enrollment in the program. Individual members or dependents who did not apply for health coverage at the time it was last offered by the guaranteed association but at that time had other employer sponsored health coverage or coverage under the federal Medicare program pursuant to Title XVIII of the Social Security Act, who apply for coverage in the program within thirty (30) calendar days of a loss of the other coverage will not be considered to be a late applicant if the member or dependent can demonstrate that he or she had other coverage at the time the guaranteed association offered coverage.

(dd) "Member employee" means any permanent employee employed by a member employer for at least thirty (30) consecutive calendar days who is actively engaged on a full-time basis in the conduct of the business of the member employer with a normal workweek of at least thirty (30) hours, at the member employer's regular place or places of business. The term includes sole proprietors or partners in a partnership, if they are actively engaged on a full time basis with a normal work week of at least 30 hours in the member employer's business and included as employees under a health care plan contract of a member employer, but does not include employees who work on a part-time, temporary, or substitute basis. To be considered a member employee an employee shall be paid by the member employer as a permanent employee. An employee who has been on paid leave for more than ninety (90) days in a year from the effective date of coverage in the program or more than ninety (90) days in any subsequent twelve month period of coverage in the program shall cease to be considered a member employee unless on leave pursuant to the federal Family and Medical Leave Act of 1993 (P.L. 103-3), and/or California Government Code Sections 12945 and 12945.2. An employee on unpaid leave shall not be considered a member employee unless on leave pursuant to the federal Family and Medical Leave Act of 1993 and/or California Government Code Sections 12945 and 12945.2. Employees who waive coverage on the grounds that they have other employer sponsored health coverage or coverage under the federal Medicare program pursuant to Title XVIII of the Social Security Act shall not be considered or counted as member employees.

(ee) "Member employer" means either a sole employer which purchases coverage in the program as a member of a qualified guaranteed association or an employer which would be a sole employer if it had no more than 50 eligible employees which purchases coverage in the program as a member of a qualified guaranteed association.

(ff) "Participating carrier" means a carrier that has entered into a contract with the program to provide health benefits coverage.

(gg) "Participating dental carrier" means a dental carrier that has entered into a contract with the program to provide dental benefits coverage.

(hh) "Participating employer" means a small employer who has been accepted into the program.

(ii) "Preexisting condition" means a condition for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(jj) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage for any preexisting condition.

(kk) "Preferred provider organization" means health benefits plans under which retrospective payment is made by a carrier under contracts that define rates of payment with physicians, hospitals, or other providers of health services rendered to subscribers.

(*ll*) "Pre-paid dental organization" means individual practice prepayment plans or network model prepayment plans which offer dental services in whole or in part on a prepaid basis, with professional services thereunder provided by individual dentists or groups of dentists or other providers of dental services who agree to accept the payment provided by the plans as full payment for covered services rendered by them.

(mm) "Program participation fee" means the amount charged to a small employer or individual member to participate in the program pursuant to Section 2699.6307.

(nn) "Program" means the Voluntary Alliance Uniting Employers Purchasing Program which shall be known as "The Health Insurance Plan of California."

(oo) "Qualified guaranteed association" means an association that has been determined to be in compliance with the participation requirements of Section 2699.6109 of this part.

(pp) "Qualified individual member" means an individual member that has been determined to be in compliance with the participation requirements of Section 2699.6113 of this part.

(qq) "Qualified member employer" means a member employer that has been determined to be in compliance with the participation requirements of Section 2699.6111.

(rr) "Qualified sole employer" means a sole employer that has been determined to be in compliance with the participation requirements of Section 2699.6107 of this part.

(ss) "Qualifying prior coverage" means:

(1) Any individual or group policy, or contract, or program, this is written or administered by a disability insurer, nonprofit hospital service plan, health care service plan, fraternal benefits society, self insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.

(tt) "Qualifying prior dental coverage" means:

(1) Any individual or group policy, or contract, or program, that is written or administered by a disability insurer, nonprofit dental service plan, dental service plan, fraternal benefits society, self-insured employer dental plan, or any other entity, in this state or elsewhere, and that arranges or provides dental coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, longterm care, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers'

compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) Any other publicly sponsored program, provided in this state or elsewhere, of dental care.

(uu) "Rating period" means the period for which premium rates for a participating carrier are in effect.

(vv) Rounding of percentage. Whenever in this part a percentage is calculated or referenced the resulting number will be rounded to the nearest whole integer.

(ww) "Small employer" means a sole employer or member employer.

(xx) "Sole employee" means any permanent employee employed by a qualified sole employer for at least thirty (30) consecutive calendar days who is actively engaged on a full-time basis in the conduct of the business of the qualified sole employer with a normal workweek of at least thirty (30) hours, at the qualified sole employer's regular place or places of business. The term includes sole proprietors or partners in a partnership, if they are actively engaged on a full time basis with a normal work week of at least 30 hours in the qualified sole employer's business and included as employees under a health care plan contract of a qualified sole employer, but does not include employees who work on a part-time, temporary, or substitute basis. To be considered a sole employee an employee shall be paid by the sole employer as a permanent employee. An employee who has been on paid leave for more than ninety (90) days in a year from the effective date of coverage in the program or for more than ninety (90) days in any subsequent twelve month period shall cease to be considered a sole employee unless on leave pursuant to the federal Family and Medical Leave Act of 1993 (P.L. 103-3), and/or California Government Code Sections 12945 and 12945.2. An employee on unpaid leave shall not be considered a member employer unless on leave pursuant to the federal Family and Medical Leave Act of 1993 and/or California Government Code Sections 12945 and 12945.2. Employees who waive coverage on the grounds that they have other employer sponsored health coverage or coverage under the federal Medicare program pursuant to Title XVIII of the Social Security Act shall not be considered or counted as sole employees.

(yy) "Sole employer" means any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50% of its working days during the preceding calendar quarter employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, which was not formed primarily for the purposes of buying health coverage and in which a bona fide employer-employee relationship exists. However, the definition shall include employers with at least four eligible employees until July 1, 1995, three eligible employees until July 1, 1997 and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. For purposes of these regulations sole employers who participate in the program as member employers will be considered member employers.

(zz) "Social Security Number" means the account number assigned to an individual by the United States Social Security Administration in order to make payments and obtain benefits under the Social Security Act. The Social Security Number is necessary for use by the program as a unique identifier in order to track an enrollee's status in the program, and for ongoing administration. The Social Security Number will be shared with the program's central enroller contractor and with the carrier contractor selected by the enrollee. The use of the Social Security Number in the program is protected under The Federal Privacy Act of 1974 (Public Law 93-579) and the State Information Practices Act of 1977 (Civil Code Section 1798 et seq.).

(aaa) "Tenses, and Number." The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

(bbb) "Time." Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Relocating of article heading and renumbering and amendment of former section 2699.610 to section 2699.6000 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).
2. Amendment filed 5-23-94 as an emergency; operative 5-23-94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9-20-94 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 5-23-94 order transmitted to OAL 9-16-94 and filed 10-27-94 (Register 94, No. 43).
4. Amendment of subsection (k), new subsection (*l*), subsection relettering, and amendment of newly designated subsections (o)(1), (q), (r), (s), (x), (mm), (oo)(2), (pp)(1) and (uu) filed 12-29-94 as an emergency; operative 12-29-94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4-28-95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 12-29-94 order including amendment of subsections (r) and (oo)(1) transmitted to OAL 4-12-95 and filed 5-22-95 (Register 95, No. 21).
6. Amendment of subsections (z) and (tt) filed 6-16-95 as an emergency; operative 6-16-95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 10-16-95 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 6-16-95 order transmitted to OAL 9-26-95 and filed 10-18-95 (Register 95, No. 42).
8. New subsection (p) and subsection relettering filed 5-2-96; operative 6-1-96 (Register 96, No. 18).
9. Amendment of subsections (i) and (vv) filed 5-5-97; operative 7-1-97 (Register 97, No. 19).
10. Amendment filed 7-3-98 as an emergency; operative 7-3-98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11-2-98 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 7-3-98 order, including amendment of section, transmitted to OAL 10-2-98 and filed 11-16-98 (Register 98, No. 47).
12. Editorial correction (Register 99, No. 6).

Article 2. Participation Requirements, Application And Enrollment

§ 2699.6100. Non-Discrimination.

(a) The program shall be administered without regard to sex, race, creed, color, sexual orientation, national origin, disability, or occupation.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Relocation of article heading and renumbering of former section 2699.620 to section 2699.6100 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).

§ 2699.6103. Availability of Benefit Plan Designs.

The program may make available to eligible employees and dependents health benefits plans which are health maintenance organizations, preferred provider organizations or exclusive provider organizations. For eligible employees and dependents who reside in the United States of America but outside the state of California, the program may also make available health benefits plans which are indemnity plans.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6205 to section 2699.6103 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).
2. Amendment of section and new NOTE filed 5-2-96; operative 6-1-96 (Register 96, No. 18).

§ 2699.6105. Availability of Dental Benefit.

The program may make available to sole employees and guaranteed association members, and their dependents, who reside in the state, dental benefit plans which are pre–paid dental organizations or fee–for–service dental organizations.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6107. Participation Requirements for Sole Employers.

(a) Qualified sole employers shall be eligible to participate in the program to provide health benefits coverage for sole employees and their dependents.

(b) To be a qualified sole employer, a sole employer shall be a sole employer as defined as of the effective date of coverage and shall meet the following requirements:

(1) Inform all potential sole employees of the employer's intention to purchase coverage through the program and provide them the opportunity to apply for coverage.

(2) Provide all potential sole employees with at least thirty (30) calendar days to decide whether to apply for coverage and choose their health benefit plan; this shall be done for all potential sole employees in a consistent time and manner.

(3) Inform all potential sole employees of the amount the employer will contribute toward the purchase of coverage.

(4) For each potential sole employee who declines to apply for coverage or who fails to request coverage for all of his or her dependents, the employer shall do one of the following:

(A) For an employee waiving because the employee and/or the employee's dependents have health coverage under the terms of another employer benefit plan or coverage under the federal Medicare program pursuant to Title XVIII, the employer shall obtain from the employee a certification that the employee is waiving because the employee and/or his or her dependents have coverage under another health benefit plan.

(B) For any employee declining coverage who fails to make the certification in (A) above, require the employee to sign a written statement, the content of which will be provided by the program, which informs the employee that failure to enroll for coverage during the enrollment period will result in the employee being unable to enroll himself or herself or dependents with the program until the program's next open enrollment period. The form is contained in the HIPC application booklet.

(5) Maintain at the sole employer's principal place of business copies of the certifications and written statements required by (4) above for a period of one (1) year.

(6)(A) For sole employers who have an effective date of coverage prior to September 1, 1998, who have not made an election pursuant to Section 2699.6116, for every employee who enrolls in the program, the sole employer shall contribute an amount equal to at least 50% of the monthly "employee only" rate of the lowest "employee only" rate available to the eligible employee.

(B) For sole employers who have an effective date of coverage on or after September 1, 1998, and sole employers who made an election pursuant to Section 2699.6116, for every employee who enrolls in the program, the sole employer shall contribute an amount equal to at least 50% of the lowest available monthly employee only comprehensive individual medical premium.

(7) For sole employers of four (4) or more eligible employees, at least 70% of the eligible employees shall be enrolled in the program unless the sole employer contributes 100% of the "employee only" rate in which case 100% of the eligible employees shall be enrolled in the program. For sole employers of two (2) or three (3) eligible employees, all of the eligible employees shall be enrolled in the program. At the time of the initial application, this determination shall be made as of the effective day of coverage for the group.

(8) One hundred percent of the eligible employees enrolling in the program shall be covered by workers' compensation insurance except those eligible employees who are not legally required to be covered by workers' compensation insurance.

(9) Inform the program when an eligible sole employee or dependent ceases to be eligible by the end of the month in which the event occurs.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.621 to section 2699.6107 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (b), (b)(4)(A), (b)(4)(B), (b)(7), and (b)(8) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
4. Amendment of subsections (b), (b)(7) and (b)(9) filed 6–16–95 as an emergency; operative 6–16–95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–16–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–16–95 order transmitted to OAL 9–26–95 and filed 10–18–95 (Register 95, No. 42).
6. Amendment of subsection (b)(7) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).
7. Redesignation and amendment of former subsection (b)(6) to new subsection (b)(6)(A) and new subsection (b)(6)(B) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6109. Participation Requirements for Guaranteed Associations.

(a) Qualified guaranteed associations shall be eligible to participate in the program to provide health benefits coverage for member employees and individual members. To be a qualified guaranteed association, a guaranteed association shall meet the following requirements:

(1) Send a notice to all members of the association, as well as any other person known to the association who although not an association member is in a category of persons who pursuant to (a)(9) below will be eligible for coverage through the guaranteed association, at their last known address that they may elect coverage through the guaranteed association, and that if they meet the qualifications to be a member employer, they may elect to provide coverage for their member employees through the guaranteed association. The notice shall state in bold face type that failure to elect coverage during the enrollment period permits the program to impose, at the time of the employer or person's later decision to elect coverage, an exclusion from coverage until the next open enrollment period, as well as, depending on the participating carrier selected by the person, a six months preexisting condition exclusion once enrolled, unless the individual member can demonstrate that he or she had other employer health coverage during the time of the enrollment period, or has been directed by court order to provide coverage for a spouse or minor child and the person has applied within thirty (30) days of losing that coverage. In addition to the initial notice, such notice shall be provided to all members who later join the guaranteed association and persons who become members of a sponsored category within 30 days of the date they become members of the guaranteed association or sponsored category.

(2) Provide all potentially qualified member employers and individual members with at least thirty (30) calendar days to decide whether to apply for coverage through the program.

(3) Maintain for a period of one (1) year at the guaranteed association's principal place of business a copy of any notice required by (1) above as well as a list detailing to whom the notice was mailed and when.

(4) Not offer coverage anywhere but in the program.

(5) Provide coverage in the program to at least 1000 persons except for the following:

(A) Sixty (60) days prior to the expiration of an existing plan contract that expires prior to July 1, 1994, or, for plan contracts expiring after July 1, 1994, sixty (60) days prior to July 1, 1994 an association that meets the definition of a guaranteed association pursuant to Section 2699.6000 of this part, except for the requirements that one thousand (1,000) persons be covered, shall be able to participate in the program as if the association were a qualified guaranteed association if the persons sponsored by the association satisfy the criteria specified in (B) below.

(B) Persons determined to be eligible pursuant to (9) below applying to the program pursuant to (A) above shall not be qualified unless they:

1. Have been receiving coverage or had successfully applied for coverage through the association as of June 30, 1993, or

2. Have been receiving coverage through the association as of December 31, 1992, and whose coverage lapsed at any time thereafter because the employment through which coverage was received ended or an employer's contribution to health coverage ended, or

3. Have been covered at any time between June 30, 1993, and July 1, 1994, under a contract that was in force on June 30, 1993.

(6) Maintain at the guaranteed association's principal place of business and provide to the program upon request documents that verify that:

(A) The guaranteed association membership includes one or more employers meeting the criteria of a sole employer as defined in Section 2699.6000.

(B) The guaranteed association does not condition membership directly or indirectly on the health claims history of any person,

(C) The guaranteed association uses membership dues solely for and in consideration of the membership and membership benefits,

(D) The guaranteed association is organized and maintained for purposes unrelated to insurance,

(E) The guaranteed association was in active existence on January 1, 1992, and for at least five (5) years prior to that date,

(F) The guaranteed association has been offering health insurance to its members that reside in California for at least five (5) years prior to January 1, 1992, and

(G) The guaranteed association has governing documents that provide for the election of its governing board by the membership of the association.

(7) For a guaranteed association that has provided coverage to its members through the mechanism of a trust, the guaranteed association shall provide at the program's request documentation that membership in the trust is coincidental with membership in the guaranteed association or that individual members are retired members or the spouse or dependents of a deceased member.

(8) Provide to the program documents that illustrate that the member employers and individual members purchasing coverage through the program are bona fide members of the guaranteed association or that individual members are retired members or a spouse of a deceased member, and provide to the program the beginning date of membership for each member employer and individual member.

(9) Determine what categories of persons who are not otherwise association members the guaranteed association will sponsor for coverage as members. These may only include employees of members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. The guaranteed association shall commit to the program that the specified offering will continue until the guaranteed association's annual requalification.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.621.5 to section 2699.6109 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

2. Amendment of subsections (a)(1)–(3) and NOTE filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

4. Amendment of subsection (a)(9) filed 4–25–96; operative 5–25–96 (Register 96, No. 17).

§ 2699.6111. Participation Requirements for Member Employers.

(a) Qualified member employers shall be eligible to participate in the program to provide health benefits coverage for member employees and their dependents.

(b) To be a qualified member employer, a member employer shall meet the following requirements:

(1) Be a member employer of a qualified guaranteed association before applying to the participate in the program and continue to be a member employer of a qualified guaranteed association while participating in the program.

(2) Meet the requirements specified for sole employers in Section 2699.6107(b), except that in Subsection 2699.6107(b)(6), the effective date of coverage shall refer to that of the guaranteed association, not the member employer.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.621.6 to section 2699.6111 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

2. Amendment of subsection (b)(2) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6113. Participation Requirements of Individual Members.

(a) Qualified individual members of a qualified guaranteed association shall be eligible to participate in the program.

(b) To be a qualified individual member an individual member shall be:

(1) A resident of the State of California and

(2) In a category of persons the guaranteed association has designated to be sponsored for coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.621.7 to section 2699.6113 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6115. Participation Requirements for Dental Benefits Option.

(a) Only enrollees who qualify for and receive health benefits coverage in the program shall be eligible to receive dental benefits coverage through the program.

(b) If a small employer elects the dental benefit option:

(1) 100% of the eligible employees participating in the program for health benefits shall participate in the program for dental benefits, and any dependents enrolled for health benefits shall be enrolled for dental benefits, with the exception that dependents under the age of two years are not required to participate, and

(2)(A) For sole employers who have an effective date of coverage prior to September 1, 1998, who have not made an election pursuant to Section 2699.6116, and member employers whose guaranteed association has an effective date of coverage prior to September 1, 1998 and did not make an election pursuant to Section 2699.6116, for each such employee a small employer shall contribute an amount equal to at least 50% of the monthly "employee only" rate of the lowest "employee only" rate available to the employee for dental benefits.

(B) For sole employers who have an effective date of coverage on or after September 1, 1998, or who have made an election pursuant to Section 2699.6116, and member employers whose guaranteed association has an effective date of coverage on or after September 1, 1998, or made an election pursuant to Section 2699.6116, for each such employee a

small employer shall contribute an amount equal to at least 50% of the lowest available monthly employee only comprehensive individual dental premium.

(c) If a qualified guaranteed association elects to make the dental benefit option available to individual members, 100% of the individual members of the qualified guaranteed association participating in the program for health benefits shall participate in the program for dental benefits and any dependents enrolled for health benefits shall be enrolled for dental benefits, with the exception that dependents under the age of two years are not required to participate.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted with amendment of subsection (b)(1) to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
3. Redesignation and amendment of former subsection (b)(2) to new subsection (b)(2)(A) and new subsection (b)(2)(B) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6116. Fee Structure Election.

(a) Participating sole employers and guaranteed associations with an effective date of coverage prior to September 1, 1998, may elect to participate under the agent fee and program participation fee structures applicable to sole employers and guaranteed associations with an effective date of coverage on or after September 1, 1998. If a guaranteed association makes an election, each member employer and individual member of that association shall be deemed to have made an election. If such an election is made it must be made in writing by October 1, 1998 and is irrevocable.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6117. Annual Requalification for Sole Employers.

(a) Each participating sole employer will be reevaluated annually to determine if it continues to be a qualified sole employer as defined in Section 2699.6000. If a participating sole employer has at least two (2) eligible employees at the time of the sole employer's annual requalification and if the participating sole employer meets the requirements of Section 2699.6107, then the participating sole employer shall continue to be qualified. For purposes of this subsection only, a sole employee who is not an eligible employee at the time of the annual re–evaluation solely because of an employer–imposed waiting period but who will complete the waiting period within 30 days of the anniversary of the group's participation, and who has submitted a complete application to the program, shall be deemed an eligible employee.

(b) A participating sole employer must provide to the program all information necessary for the program's annual determination and all information necessary to verify the status of eligible employees and dependents. This information shall include a listing of all potentially eligible employees and dependents as well as a certification that the sole employer has met the requirements of Section 2699.6107.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.622 to section 2699.6117 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (a) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6119. Annual Requalification for Guaranteed Associations and Guaranteed Association Members.

(a) Each participating association will be reevaluated annually to determine if it continues to be a qualified guaranteed association. If the participating guaranteed association meets the requirements of Section 2699.6109, then the participating guaranteed association shall continue to be qualified. As part of this process the participating guaranteed association shall specify the categories of persons to be sponsored for coverage.

(b) Each participating member employer will be reevaluated annually to determine if it continues to be a qualified member employer. If a participating member employer has at least two eligible employees at the time of the participating member employer's annual requalification and if the participating member employer meets the requirements of Section 2699.6111, then the participating member employer shall continue to be qualified. For purposes of this subsection only, a member employee who is not an eligible employee at the time of the annual re–evaluation solely because of an employer–imposed waiting period but who will complete the waiting period within 30 days of the anniversary of the group's participation, and who has submitted a complete application to the program, shall be deemed an eligible employee. A participating member employer must provide to the program all information necessary for the program's annual determination and all information necessary to verify the status of eligible employees and dependents. This information shall include a listing of all potentially eligible employees and dependents as well as a certification that the member employer has met the requirements of Section 2699.6111.

(c) Each participating individual member will be reevaluated annually to determine if he or she continues to be a qualified individual member. If the participating individual member meets the requirements of Section 2699.6113, then the participating individual member shall continue to be qualified.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.622.5 to section 2699.6119 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (b) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6121. Application for Sole Employers.

(a) To apply for the program a sole employer shall submit:

(1) All information, documentation, and declarations necessary to determine program qualification and employee eligibility as set forth in subsection (d) of this section, and

(2) The name, position, and phone number of a designated contact person, and

(3) One check or money order for an amount equal to the initial one month employer premium. If the check is returned for non–sufficient funds, the application shall be considered incomplete.

(b) The sole employer shall designate a person legally authorized to sign and date required declarations on behalf of the sole employer stating that the information given is accurate and complete to the best of their knowledge.

(c) An incomplete application shall not be processed and may be returned to the sole employer.

(d)(1) The application shall contain the following:

(A) The sole employer's complete name.

(B) The sole employer's current business address including unit number, street, city, county, state, and zip code.

(C) The address to which the bills for the sole employer's premiums are to be sent, if different from (B).

(D) The sole employer's federal tax identification number.

(E) The sole employer's telephone number.

(F) The industry type of the sole employer.

(G) A copy of the sole employer's most recent state Employment Development Department's (EDD) Form DE6 (entitled "Quarterly Wage Report") Form DE 3B (entitled "Report of Wages") or Form DE 3DP (entitled "Quarterly Contribution Report") as submitted to EDD and a copy of the Federal W–4 form or employer payroll records for any employee not listed on the EDD forms submitted to the program.

(H) The name and address of the sole employer's worker's compensation carrier, and the policy number.

(I) The number of eligible employees, or employees who will be eligible by the effective date of coverage, employed by the sole employer and the number of eligible employees, or employees who will be eligible by the effective date of coverage, applying for enrollment in the program.

(J) A notification to the program of persons, if any, who can be demonstrated to have legal access to replacement coverage pursuant to California Insurance Code Section 10128.3 or California Health and Safety Code Section 1399.63.

(K) A declaration that the sole employer has informed every potential sole employee of the opportunity to obtain coverage from the participating carriers in the program and that each potential sole employee was given at least thirty (30) calendar days to respond to the opportunity.

(L) A declaration that the sole employer will inform and invite potential sole employees to respond in a consistent time and manner.

(M) A declaration that 100% of the eligible employees enrolling in the program legally required to be covered by workers' compensation insurance are so covered.

(N) A declaration that each of the employees applying for enrollment in the program is an eligible employee or will be an eligible employee by the effective date of coverage.

(O)(1) For sole employers who have an effective date of coverage prior to September 1, 1998, who have not made an election pursuant to Section 2699.6116, a declaration that the employer will contribute an amount equal to at least 50% of the lowest available employee only rate for each applying employee. If the sole employer will contribute 100% of the employee only rate, the declaration must so state.

(2) For sole employers who have an effective date of coverage on or after September 1, 1998, or who have made an election pursuant to Section 2699.6116, a declaration that the employer will contribute an amount equal to at least 50% of the lowest available employee only comprehensive individual medical premium for each applying employee. If the sole employer will contribute 100% of the employee only comprehensive individual medical premium, the declaration must so state.

(P) For sole employees with four (4) or more eligible employees, a declaration that at least 70% of the eligible employees, or employees who will be eligible as of the effective date of coverage, are applying for enrollment in the program. If the sole employer contributes 100% of the "employee only" rate or the "employee only" comprehensive individual medical premium or if the sole employer has two (2) or three (3) eligible employees, a declaration that 100% of employees who will be eligible employees as of the effective date of coverage, are applying for enrollment.

(Q) A declaration that the sole employer will abide by the rules of participation and premium payment requirements of the program.

(R) A declaration that those eligible employees who have declined coverage in the program for themselves or for any of their dependents have signed a form explaining to them that they will be unable to enroll in the program until the program's next open enrollment period.

(S) A declaration by a legally authorized representative of the sole employer stating that the information is accurate and complete to the best of their knowledge.

(T)(1) For sole employers who have an effective date of coverage prior to September 1, 1998 who have not made an election pursuant to Section 2699.6116, either the agent/broker payment request specified in Section 2699.6194(a)(1) or the sole employer certification specified in Section 2699.6194(a)(2).

(2) For sole employers who have an effective date of coverage on or after September 1, 1998 or who have made an election pursuant to Section 2699.6116, the agent/broker payment request specified in Section 2699.6194(b)(2).

(2) The sole employer shall submit information for each eligible employee who is applying for enrollment that includes the following:

(A) The employee's full name.

(B) The employee's current residence address including house or unit number, street, city, county, state, and zip code.

(C) The employee's home and work phone numbers.

(D) The employee's date of birth.

(E) The employee's sex.

(F) The employee's social security number, as defined in Section 2699.6000.

(G) The employee's medical insurance information, including the carrier name and address of:

1. Any current medical insurance or other health benefits including coverage under the federal Medicare program pursuant to Title XVIII,

2. Most recent prior medical insurance or other health benefits.

(H) The employee's date of employment with the sole employer, the number of hours in the employee's normal workweek, and the date, if different from the employment date, that the employee began a normal workweek of at least thirty (30) hours.

(I) If dependents are to be included in the coverage, the full names, dates of birth, sex, social security numbers as defined in Section 2699.6000, if available, relationship of the dependents to be covered and medical insurance information for each dependent as specified in (G) above.

(J) The participating carrier and health benefits plan that the eligible employee is selecting for coverage.

(K) A signed and dated declaration by the eligible employee that declares the following:

1. The employee will follow the rules and regulations of the program.

2. The employee has reviewed the services and coverage offered by the participating carriers and the premium rates of the participating carriers.

3. The employee resides in the service area of his/her selected participating carrier.

4. The employee will abide by the rules, utilization review process, and dispute resolution process of the participating carrier which the eligible employee has selected.

5. The employee understands that he or she meets the program requirements to be an eligible employee.

6. The information given is true and correct.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.623 to section 2699.6121 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (d)(1)(I), (d)(1)(M) and (d)(1)(O) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Change without regulatory effect amending subsection (d)(1)(G) filed 5–5–95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 18).
4. Certificate of Compliance as to 12–29–94 order including amendment of subsection (d)(1)(O) transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
5. Amendment of subsections (d)(1)(G), new subsection (d)(1)(J), subsection relettering, and amendment of newly designated subsection (d)(1)(P) filed 6–16–95 as an emergency; operative 6–16–95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–16–95 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–16–95 order transmitted to OAL 9–26–95 and filed 10–18–95 (Register 95, No. 42).
7. Amendment of subsection (d)(1)(P) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

8. Redesignation and amendment of former subsection (d)(1)(O) to new subsection (d)(1)(O)(1), new subsection (d)(1)(O)(2), amendment of subsection (d)(1)(P), redesignation and amendment of former subsection (d)(1)(T) to new subsection (d)(1)(T)(1) and new subsection (d)(1)(T)(2) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6123. Application for Guaranteed Associations.

(a) To apply for the program a guaranteed association shall submit:

(1) The name, position, and phone number of a designated contact person who is legally authorized to sign and date required declarations on behalf of the guaranteed association stating that the information given is true and correct and complete to the best of their knowledge.

(2) All information, documentation, and declarations necessary to determine program qualification as follows:

(A) A list of all members of the association including their name, address, beginning date of membership, membership category and tax identification number, if available.

(B) A list of the member employers, member employees and dependents, and individual members and dependents who currently have coverage sponsored by the guaranteed association or through the guaranteed association's trust through which the guaranteed association sponsors coverage.

(C) A declaration that the guaranteed association has one or more employers which meets the definition of a sole employer.

(D) A declaration that the guaranteed association does not condition membership directly or indirectly on the health or claims history of any person.

(E) A declaration that the guaranteed association uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(F) A declaration that the guaranteed association is organized and maintained in good faith for purposes unrelated to providing insurance to members.

(G) A declaration that the guaranteed association has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(H) Written proof that the guaranteed association was in active existence on January 1, 1992 and for at least five years prior to that date.

(I) Written proof that the guaranteed association has been offering health insurance to its members for at least five years prior to January 1, 1992.

(J) A declaration by the guaranteed association that the guaranteed association will notify all association members as well as any other person known to the association who, although not an association member, is in a category of persons who pursuant to Section 2699.6109(a)(9) will be eligible for coverage through the guaranteed association of the guaranteed association's intention to offer coverage through the program and provide member employers and individual members with at least a 30 day period to respond.

(K) A declaration stating when the period for informing member employers and individual members of the availability of coverage in the program will be and for how long it will be.

(L) A declaration stating that the guaranteed association will meet the requirements of Section 2699.6109(a)(2) and (a)(3).

(M) A declaration that the guaranteed association will not offer coverage to member employers and their employees or to individual members anywhere but in the program.

(N) A declaration disclosing to the program the number of persons currently receiving coverage through the guaranteed association and when that coverage commenced.

(O) A specification by the guaranteed association of which of the members, employees of members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members the association shall commit to offering coverage to in the program.

(3) A description of the guaranteed association's plan for offering coverage. This shall include at least the following:

(A) The method for providing notice of the offering of coverage in the program.

(B) The date the initial offering by the guaranteed association will expire.

(C) Whether applications and premiums will be submitted through the guaranteed association or directly to the program.

(D) If the applications and premiums will be submitted through the guaranteed association, whether the guaranteed association will be utilizing the services of an agent or broker. If the guaranteed association will be utilizing the services of an agent or broker, the name, license number, tax identification number, and address of the agent or broker.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.623.5 to section 2699.6123 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (a)(2)(O) filed 4–25–96; operative 5–25–96 (Register 96, No. 17).
3. Amendment of subsection (a)(3)(D) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6125. Member Employer Application.

(a) To apply for the program a member employer shall comply with the requirements set forth in Section 2699.6121, except that in (d)(1)(O), the effective date of coverage shall refer to that of the guaranteed association, not the member employer, and shall provide the name of the member employer's qualified guaranteed association.

(b) Applications shall be submitted to the guaranteed association if the guaranteed association has so elected. If the guaranteed association has not so elected the application shall be submitted to the program.

(c) An incomplete application shall not be processed and may be returned to the member employer.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.623.6 to section 2699.6125 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (a) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6127. Application for Individual Members.

(a) To apply for the program an individual member shall submit:

(1) All information, documentation, and declarations as set forth in Section 6121(d)(2) for sole employees except for Section 6121(d)(2)(H).

(2) The name of the individual member's qualified guaranteed association.

(3) A declaration by the individual member stating the relationship of the individual member to her or his guaranteed association as determined by the guaranteed association pursuant to Section 2699.6109(a)(9).

(4) One check or money order for an amount equal to the initial one month individual premium. If the check is returned for non–sufficient funds, the application will be considered incomplete.

(b) Applications shall be submitted to the guaranteed association if the guaranteed association has so elected. If the guaranteed association has not so elected the applications shall be submitted to the program.

(c) An incomplete application shall not be processed and may be returned to the individual member.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.623.8 to section 2699.6127 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6129. Application for Dental Benefits Coverage.

(a) Applications for dental benefits shall be in addition to the applications for participation in the program pursuant to Sections 2699.6121, 2699.6123, 2699.6125, and 2699.6127.

(b) Small employers or guaranteed associations may elect the dental coverage option at the following times:

(1) During the special initial election for dental benefits coverage pursuant to Section 2699.6157, or

(2) At the time of application for the program, or

(3) During open enrollment pursuant to Section 2699.6143.

(c) Small employers shall submit the following in an application for dental benefits:

(1) A declaration that 100% of the eligible employees participating in the program for health benefits will purchase dental benefits.

(2)(A) For small employers who have an effective date of coverage prior to September 1, 1998, who have not made an election pursuant to Section 2699.6116, a declaration that the small employer is contributing an amount equal to at least 50% of the monthly "employee only" rate of the lowest "employee only" rate available to the eligible employee for dental benefits coverage.

(B) For small employers who have an effective date of coverage on or after September 1, 1998, or who have made an election pursuant to Section 2699.6116, a declaration that the small employer is contributing an amount equal to at least 50% of the lowest available monthly "employee only" comprehensive individual dental premium.

(3) Payment of an amount equal to the initial one month dental benefits premium or the sum of the initial one month comprehensive individual dental premiums as applicable. This shall be paid as part of the employer premium except during the special initial election for dental benefits coverage pursuant to Section 2699.6157 when the initial one month dental benefits premium may be paid before the employer premium to facilitate an earlier effective date for dental benefits.

(4) An application for each eligible employee which indicates:

(A) Name, address, and Social Security Number, as defined in Section 2699.6000, of each eligible employee applying for dental benefits.

(B) The employee's and dependent's, if applicable, dental insurance information, including the carrier name and address of:

1. Any current dental insurance or other dental benefits.

2. Most recent prior dental insurance or other dental benefits.

(C) Which dental benefit plan the eligible employee is selecting for dental benefits.

(d) Individual members shall submit the following in an application for dental benefits:

(1) Name, address, and Social Security Number, as defined in Section 2699.6000, of the individual member,

(2) The individual member's and dependent's, if applicable, dental insurance information, including the carrier name and address of:

(A) Any current dental insurance or other dental benefits.

(B) Most recent prior dental insurance or other dental benefits.

(3) Which dental benefit plan the individual member is selecting for dental benefits.

(4) Payment of an amount equal to the initial one month dental benefit premium or the comprehensive individual dental premium as applicable. This shall be paid as part of the individual member premium, except during the special initial election for dental benefits coverage pursuant to Section 2699.6157 when the initial one month dental benefits premium may be paid before the individual member premium to facilitate an earlier effective date for dental benefits.

(e) If a guaranteed association elects the dental benefit option, a guaranteed association shall certify in its application that all individual members of the guaranteed association will be purchasing dental benefits from the program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted with amendment of subsections (b)(1), (c)(3) and (d)(4) to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
3. Amendment of subsection (b)(3) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
5. Redesignation and amendment of former subsection (c)(2) to new subsection (c)(2)(A), new subsection (c)(2)(B), and amendment of subsections (c)(3) and (d)(4) filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6131. Initial Sole Employer Qualification and Sole Employee Enrollment Period.

(a) Upon receipt of a complete application, the program shall determine the sole employer's qualification for the program, determine the eligibility of each of the sole employer's employees that apply for coverage, and determine whether each person for whom coverage as a dependent has been requested is a dependent. The program may rely upon the application to determine the sole employer's qualification; this determination shall be made within ten calendar days of receipt of the complete application.

(b) Sole employers determined not qualified for the program will be notified in writing by the program. The notice shall include the reason for the determination of disqualification and an explanation of the appeal process. The sole employer's initial premium shall be refunded.

(c) If an employee of a qualified sole employer is determined by the program not to be a sole employee as of the effective date of coverage, or if a person for whom coverage as a dependent has been requested is determined not to be a dependent, the sole employer shall be notified of the determination and the sole employer shall notify the employee. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the sole employer's initial premium covering amounts owed for coverage to persons found either to be ineligible or not a dependent shall be refunded.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.624 to section 2699.6131 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (c) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6133. Initial Qualification for the Program for Guaranteed Associations and Association Members.

(a) Upon receipt of a complete application from a guaranteed association, the program shall determine tentatively the guaranteed association's qualification for the program subject to compliance with Subsection 2699.6109(a)(5). Upon tentative determination that the guaranteed association is a qualified guaranteed association, the program in consultation with the qualified guaranteed association shall institute a process for gathering applications from member employers, member employees,

and individual members. No application from a member employer, member employee, or individual member shall be considered complete until the guaranteed association is determined to be qualified for participation in the program.

(b) Upon receipt of a complete application from a member employer, at any time other than open enrollment, the program shall determine the member employer's qualification for the program, determine the eligibility of each of the employees that apply for coverage, and determine whether each person for whom coverage as a dependent has been requested is a dependent. The program may rely upon the application to determine the employer member's qualification. The determination shall be made:

(1) Within ten calendar days of receipt of a complete application from a member employer and member employees.

(c) Upon receipt of a complete application from an individual member during the initial open enrollment period of their guaranteed association, the program shall determine the individual member's qualification for the program and determine whether each person for whom coverage as a dependent has been requested is a dependent. The program may rely upon the application to determine the individual member's qualification. The determination shall be made after sixty (60) calendar days and within seventy (70) calendar days of receipt of a complete application from an individual member. However, if the individual member has qualifying prior coverage at the time of application the determination shall be made within ten (10) calendar days.

(d) Guaranteed association members determined not qualified for the program will be notified in writing by the program. The guaranteed association shall also be notified. The notice shall include the reason for the determination of disqualification and an explanation of the appeal process. The guaranteed association member's initial premium shall be refunded.

(e) If an employee of a qualified member employer is determined not to be a sole employee by the program, or if a person for whom coverage as a dependent has been requested is determined not to be a dependent, the member employer shall be notified of the determination and the member employer shall notify the employee. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the member employer's initial premium covering amounts owed for coverage to persons found either to be ineligible or not a dependent shall be refunded.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering of former section 2699.624.5 to section 2699.6133 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (a), (b), (c) and (e) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6135. Waiting Period for Sole Employees.

Sole employees who decline coverage under the program or any dependents for whom sole employees decline coverage shall be ineligible to enroll in the program until the program's next open enrollment period.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6241 to section 2699.6135 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6137 Waiting Period for Guaranteed Association Members.

Employee members or dependents who decline coverage under the program or individual members or dependents who do not apply during the enrollment period shall be ineligible to enroll in the program until the program's next open enrollment period.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6241.5 to section 2699.6137 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6139. Open Enrollment Period for Sole Employers.

(a) The program shall provide for an annual open enrollment period which shall last for at least thirty (30) consecutive days. During this period, enrolled sole employees may transfer from one health benefits plan to another, sole employees may choose to enroll themselves and their dependents in the program and enrolled sole employees may choose to enroll their dependents.

(b) Late applicants may enroll during this period.

(c) If a sole employee of a qualified sole employer is determined not to be a sole employee by the program, or if a person for whom coverage as a dependent has been requested is determined not to be a dependent, the sole employer shall be notified of the determination and the sole employer shall notify the sole employee. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the sole employer's premium covering amounts owed for coverage to persons found either to be ineligible or not a dependent shall be refunded.

(d) For sole employees applying during an open enrollment period, the sole employer shall provide the following:

(1) For sole employees transferring to a new health benefits plan:

(A) Name.

(B) Address.

(C) Social Security Number, as defined in Section 2699.6000.

(D) Current Health Benefits Plan.

(E) New Health Benefits Plan.

(F) Name and social security number, as defined in Section 2699.6000, and, if available, for enrolled dependents.

(2) For sole employees or dependents who have not previously been enrolled:

(A) The information required by Section 2699.6121(d)(2) of this part,

(3) The sole employer's most recent state EDD Form DE–6 (entitled "Quarterly Wage Report") or Form DE3B (entitled "Report of Wages") or DE3DP (entitled "Quarterly Contribution Report") as submitted to the EDD and a copy of the Federal W–4 form or employer payroll records for any employee not listed on the EDD forms submitted to the program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6242 to section 2699.6139 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (d)(2)(A)(3) filed 10–18–95; operative 10–18–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 42).

§ 2699.6141. Open Enrollment Period for Guaranteed Association Members.

(a) The program shall provide for an annual open enrollment period which shall last for at least thirty (30) calendar days for guaranteed association members. During this period, enrolled member employees or individual members may transfer from one health benefits plan to another, member employees or individual members may choose to enroll themselves and their dependents in the program and enrolled member employees or individual members may choose to enroll their dependents.

(b) Late applicants may enroll during this period.

(c) If an employee of a qualified member employer or an individual member who applies during open enrollment is determined not to be eligible by the program, or if a person for whom coverage as a dependent has been requested is determined not to be a dependent, the individual member or the member employer shall be notified of the determination. The member employer shall notify the member employees. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the individual premium covering amounts owed for coverage to persons found either to be ineligible or not a dependent shall be refunded.

(d) For member employees or individual members applying during an open enrollment period, the information required by Section 2699.6139(d) shall be submitted by the employer or individual member. Individual members shall not be required to submit state EDD wage reporting forms.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6242.5 to section 2699.6141 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (d) filed 10–18–95; operative 10–18–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 42).

§ 2699.6143. Open Enrollment for Dental Benefits.

(a) The program shall provide for an annual open enrollment period for dental benefits which shall last for at least (30) thirty consecutive days.

(b) During open enrollment the following may occur:

(1) Eligible employees and individual members, and dependents, who are enrolled for dental benefits may transfer from one dental benefits plan to another.

(2) Small employers and guaranteed associations may elect the dental benefit option.

(c) Small employers and individual members shall provide the following for employees or individual members transferring to a new dental benefits plan:

(1) Name.

(2) Address.

(3) Social Security Number, as defined in Section 2699.6000.

(4) Current dental benefits plan.

(5) New dental benefits plan.

(6) Name and Social Security Number, as defined in Section 2699.6000, if available, for enrolled dependents.

(d) Small employers which elect the dental benefit option during open enrollment shall submit an application for dental benefits pursuant to Subsection 2699.6129(c).

(e) Individual members of a guaranteed association that has elected the dental benefit option during open enrollment shall submit an application for dental benefits pursuant to Subsection 2699.6129(d).

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operate 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6145. Other Enrollment Additions by Sole Employers for Employees.

The following shall apply to applications for coverage in the program for sole employees and/or their dependents who are not late applicants and which were not part of the initial application of the qualified sole employer or submitted during an open enrollment process. An application for coverage shall be made within 45 days prior to or 60 days after the date the employee becomes an eligible employee. If the application is not made by 60 days after the employee became eligible, the employee shall be considered a late applicant, and also:

(a) For each sole employee whom the sole employer seeks to add, a sole employer shall notify the program in the manner specified by the program of:

(1) The information required by Section 2699.6121(d)(2) of this part.

(2) A declaration that the sole employee is an eligible employee.

(3) If the sole employee for whom coverage is requested previously waived or dropped coverage because he or she had coverage under another employer's sponsored group plan, a copy of the certification signed by the eligible employee attesting to his or her coverage if applicable, written proof of the eligible employee's previous coverage, and the date of termination of the previous coverage.

(b) A sole employer, wishing to enroll additional dependents of enrolled employees shall notify the program in the manner specified by the program of:

(1) The information required by Section 2699.6121(d)(2)(I) of this part,

(2) If the sole employee requesting coverage previously waived or dropped coverage for the dependent because the dependent had coverage under another employer's sponsored group plan, a copy of the certification signed by the sole employee attesting to the dependent's coverage, written proof of the dependent's previous coverage, and the date of termination of the previous coverage,

(3) The birth or adoption of a child, or the addition of a stepchild or spouse, within thirty (30) calendar days of the event to continue coverage of the newborn, adopted child, stepchild, or spouse.

(4) If a court has ordered an enrolled sole employee to enroll the dependent(s) in his or her health benefit plan, a written statement by the employee that a court has ordered the employee to provide the coverage.

(c) If an employee of a qualified sole employer is determined not to be an eligible employee by the program, or if a person for whom coverage as a dependent has been requested is determined not to be an eligible dependent, the sole employer shall be notified of the determination and the sole employer shall notify the employee. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the sole employer's premium covering amounts owed for coverage to persons found either to be ineligible or not an eligible dependent shall be refunded.

(d) The sole employer premium shall be adjusted, if applicable, as of the date of any change in enrollment of sole employees and/or dependents.

(e) Late applicants may not apply pursuant to this section.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6243 to section 2699.6145 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of section heading, first paragraph and subsections (b) and (c) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order including amendment of subsecdtion (b) transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6146. Later Addition of Member Employers and Individual Members.

The following shall apply to application for participation for member employers and individual members who did not apply during the initial enrollment of their guaranteed association:

(a) For member employers:

(1) A new member of the guaranteed association shall apply to participate as a member employer within 90 days of joining the guaranteed association.

(2) A current member of a guaranteed association who becomes eligible to participate as a member employer shall apply to participate as a member employer within 90 days of becoming eligible.

(3) A member of a guaranteed association who elected not to participate as a member employer during the guaranteed association's initial enrollment or open enrollment shall not be eligible to participate as a member employer until the next open enrollment.

(b) A new individual member shall apply to participate after 60 days, but within 120 days of becoming a member of the guaranteed association or of a group sponsored for coverage by the guaranteed association.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95

or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6147. Other Enrollment Additions by Member Employers for Member Employees.

The following shall apply to applications for coverage in the program for member employees and/or their dependents who are not late applicants and which were not part of the initial application period of the qualified guaranteed association or submitted during an open enrollment process. An application for coverage shall be made within 45 days prior to or 60 days after the date the employee becomes an eligible member employee. If the application is not made by 60 days after the employee became eligible, the employee shall be considered a late applicant, and also:

(a) For each member employee whom the member employer seeks to add, a member employer shall notify the program in the manner specified by the program of:

(1) The information required by Section 2699.6121(d)(2) of this part.

(2) A declaration that the employee is an eligible employee.

(3) If the employee for whom coverage is requested previously waived coverage because he or she had coverage under another employer's sponsored group plan, a copy of the certification signed by the employee attesting to his or her coverage if applicable, written proof of the eligible employee's previous coverage, and the date of termination of the previous coverage.

(b) A member employer wishing to enroll additional dependents of enrolled employees shall notify the program on an enrollment application of:

(1) The information required by Section 2699.6121(d)(2)(I) of this part,

(2) If the employee requesting coverage previously waived or dropped coverage for the dependent because the dependent had coverage under another employer's sponsored group plan, a copy of the certification signed by the employee attesting to the dependent's coverage, written proof of the dependent's previous coverage, and the date of termination of the previous coverage.

(3) The birth or adoption of a child, or the addition of a stepchild or spouse, within thirty (30) calendar days of the event to continue coverage of the newborn, adopted child, stepchild, or spouse, and

(4) If a court has ordered a member employee to enroll the dependent(s) in his or her health benefit plan, a written statement by the employee that a court has ordered the employee to provide the coverage.

(c) If an employee of a qualified member employer is determined not be an eligible employee by the program, or if a person for whom coverage as a dependent has been requested is determined not to be an eligible dependent, the member employer shall be notified of the determination and the member employer shall notify the employee. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the member employer's premium covering amounts owed for coverage of persons found either to be ineligible or not an eligible dependent shall be refunded.

(d) The member employer's premium shall be adjusted, if applicable, as of the date of any change in enrollment of eligible employee members and/or dependents.

(e) Late applicants may not apply pursuant to this section.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6243.5 to section 2699.6147 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

2. Amendment of section heading, first paragraph, subsection (a) and NOTE filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6149. Other Enrollment Additions for Individual Members.

The following shall apply to applications for coverage in the program for individual members and/or their dependents who are not late applicants and which were not part of the initial application of the qualified guaranteed association or submitted during an open enrollment process:

(a) Each application for individual members shall include:

(1) The information required by Section 2699.6127 of this part.

(2) If the individual member for whom coverage is requested previously had coverage under another employer's sponsored group plan at the time of notification by the guaranteed association, the individual member shall provide written proof of the individual member's previous coverage, and the date of termination of the previous coverage.

(b) An individual member wishing to enroll additional dependents shall provide to the program on an enrollment application:

(1) The information required by Section 2699.6127 of this part,

(2) If the individual member requesting coverage previously did not elect or dropped coverage for the dependent because the dependent had coverage under another employer's sponsored group plan at the time of notification by the guaranteed association, the individual member shall provide written proof of the dependent's previous coverage, and the date of termination of the previous coverage,

(3) Notification of the birth or adoption of a child, or the addition of a stepchild or spouse, within thirty (30) calendar days of the event to continue coverage of the newborn, adopted child, stepchild, or spouse, and

(4) If a court has ordered an enrolled individual member to enroll the dependent(s) in his or her health benefit plan, a written statement by the individual member that a court has ordered the individual member to provide the coverage.

(c) If an individual member of a qualified guaranteed association is determined not to be eligible by the program, or if a person for whom coverage as a dependent has been requested is determined not to be an eligible dependent, the individual member and the qualified guaranteed association shall be notified of the termination. The notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The portion of the individual member's premium covering amounts owed for coverage to persons found either to be ineligible or not an eligible dependent shall be refunded.

(d) The individual member's premium shall be adjusted, if applicable, as of the date of any change in enrollment of the individual member and/or dependents.

(e) Late applicants may not apply pursuant to this section.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6243.6 to section 2699.6149 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6151. Other Applications for Dental Benefits.

(a) Sole employers who have elected the dental benefits option who are applying for coverage for sole employees or dependents pursuant to Section 2699.6145 and member employers who have elected the dental benefits option who are applying for coverage for member employees or dependents pursuant to Section 2699.6147 shall comply with the application requirements of Subsection 2699.6129(c)(3) and (4).

(b) Individual members and dependents whose guaranteed association has elected the dental benefits option who are applying for coverage pursuant to Section 2699.6149 shall comply with the application requirements of Subsection 2699.6129(d).

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6153. Enrollment.

Sole employees and their dependents and guaranteed association members and their dependents who have applied to the program and have been accepted into the program shall be enrolled in a health benefit plan of the sole employee's or guaranteed association member's choice available in the service area of the sole employee's or guaranteed association member's residence.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10733, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6244 to section 2699.6153 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6155. Selection of Dental Benefit Plan.

Sole employees and their dependents and guaranteed association members and their dependents who have applied to the program for dental benefits and have been accepted by the program for dental benefits shall be enrolled in a dental benefit plan of the sole employee's or guaranteed association member's choice available in the service area of the sole employee's or guaranteed association member's residence.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10733, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.

§ 2699.6157. Special Initial Election for Dental Benefits.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10733, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
3. Repealer filed 10–18–95; operative 10–18–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 42).

§ 2699.6159. Effective Date of Coverage for Sole Employees.

(a) For enrolled sole employees and dependents, the effective date of coverage shall be as follows:

(1) For enrollees whose eligibility determination was made pursuant to Section 2699.6131(a) the effective date of coverage shall be within twenty (20) calendar days of a determination of eligibility.

(2) For enrollees who enroll or transfer pursuant to Section 2699.6139 the effective date of coverage shall be established by the program and shall be no later than forty–five (45) calendar days following the end of the open enrollment period.

(3) For enrollees who were enrolled pursuant to Section 2699.6145 the effective date of coverage shall be determined by the program and shall be no later than forty–five (45) calendar days from the receipt of a complete application.

(4) For newborn or adopted children that are dependents, the effective date of coverage shall be upon birth or adoption of the child. The effective date for coverage for stepchildren that are dependents shall be upon marriage by a sole employee to the stepchild's parent. The effective date for coverage of a spouse shall be upon marriage.

(b) The program shall notify the sole employer of the effective date and the program shall also notify the participating carrier(s) of the effective date of coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.625 to section 2699.6159 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6161. Effective Date of Coverage for Member Employees.

(a) For enrolled member employees and their dependents the effective date of coverage shall be as follows:

(1) For enrollees whose eligibility determination was made pursuant to Section 2699.6133(b) the effective date of coverage shall be within twenty (20) calendar days of a determination of eligibility.

(2) For enrollees who enroll or transfer pursuant to Section 2699.6141 the effective date of coverage shall be established by the program and shall be no later than forty–five (45) calendar days following the end of the open enrollment period.

(3) For enrollees who were enrolled pursuant to Section 2699.6147 the effective date of coverage shall be determined by the program and shall be no later than forty–five (45) calendar days from the receipt of a complete application.

(4) For newborn or adopted children that are dependents, the effective date of coverage shall be upon birth or adoption of the child. The effective date for coverage for stepchildren that are dependents shall be upon marriage by a member employee or individual member to the stepchild's parent. The effective date for coverage of a spouse shall be upon marriage.

(b) The program shall notify the member employer and the qualified guaranteed association of the effective date and the program shall also notify the participating carrier(s) of the effective date of coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.625.5 to section 2699.6161 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of section heading and subsection (a)(3) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6163. Effective Date of Coverage for Individual Members.

(a) For enrolled individual members and their dependents the effective date of coverage shall be as follows:

(1) For enrollees whose eligibility determination was made pursuant to Section 2699.6133(c) the effective date of coverage shall be within twenty (20) calendar days of a determination of eligibility.

(2) For enrollees who enroll or transfer pursuant to Section 2699.6141 the effective date of coverage shall be established by the program and shall be no later than forty–five (45) calendar days following the end of the open enrollment period.

(3) For enrollees who enroll or transfer pursuant to Section 2699.6149 the effective date of coverage shall be established by the program and shall be no later than forty–five (45) calendar days from the receipt of a complete application.

(4) For newborn or adopted children that are dependents, the effective date of coverage shall be upon birth or adoption of the child. The effective date for coverage for stepchildren that are dependents shall be upon marriage by a member employee or individual member to the stepchild's parent. The effective date for coverage of a spouse shall be upon marriage.

(b) The program shall notify the individual member and the qualified guaranteed association of the effective date and the program shall also notify the participating carrier(s) of the effective date of coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.625.6 to section 2699.6163 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (a)(3) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6165. Effective Date of Coverage for Dental Benefits.

(a) The effective date of dental coverage for an enrollee whose complete application is received by the program on or before the fifteenth day of the month shall be the first day of the next month.

(b) The effective date of dental coverage for an enrollee whose complete application is received by the program after the fifteenth day of the month shall be the first day of the month following the next month.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6167. Participating Sole Employer Disqualification.

(a) A sole employer shall be disqualified from participation in the program if any of the following occur:

(1) It is found by the program pursuant to Section 2699.6117 to no longer be a qualified sole employer. However, an employer shall not be determined to be no longer eligible to participate in the program solely because the employer employs more than 50 eligible employees, provided the employer employs no more than 100 eligible employees.

(2) It is found by the program to no longer be in compliance with the participation requirements as set forth in Section 2699.6107.

(3) It fails to pay the monthly employer premium for the enrolled sole employees and enrolled dependents as set forth in Section 2699.6311 and 2699.6313 of this chapter.

(4) It so requests in writing. Such requests shall be provided to the program at least thirty (30) calendar days prior to the effective date of the requested disqualification.

(5) It has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program.

(b) When a participating employer is disqualified pursuant to (a)(1), (a)(2), (a)(3), or (a)(5) above, the program shall notify the employer and each enrolled sole employee of the disqualification. Notices sent to enrolled sole employees shall be sent to their addresses of record.

(1) The notice shall be in writing and include the following information:

(A) The reason for the disqualification,

(B) The effective date of disqualification, and

(C) The final day of coverage provided through the program.

(2) When an employer is disqualified pursuant to (a)(2), the notice shall be sent after thirty–one (31) calendar days following the premium due date and also include a statement that the employer may again be qualified if the employer meets the requirements of Section 2699.6319 and a statement of the requirements of Section 2699.6319.

(c) An employer which is disqualified pursuant to (a)(1) above may reapply to the program whenever it again meets the requirements to be a qualified sole employer.

(d) An employer which is disqualified pursuant to (a)(2), (a)(4) or (a)(5) above, or an employer disqualified pursuant to (a)(3) above which does not reinstate pursuant to Section 2699.6319, cannot participate in the program for one (1) year from the date of disqualification.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731, 10733.5 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.626 to section 2699.6167 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (a)(1), (a)(2), (b), and NOTE filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order including amendment of subsection (a)(1) transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
4. Amendment of subsection (a)(1), new subsection (a)(2) and subsection renumbering, and amendment of subsections (b) and (d) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6169. Disqualification of Guaranteed Associations.

(a) A guaranteed association shall be disqualified from participation in the program if any of the following occur:

(1) It is found by the program to no longer be a qualified guaranteed association.

(2) It so requests in writing. Such requests shall be provided to the program at least sixty (60) calendar days prior to the effective date of the requested disqualification.

(3) It has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program.

(b) When a participating guaranteed association is disqualified, the program shall notify the guaranteed association of the disqualification.

(1) The notice shall be in writing and include the following information:

(A) The reason for the disqualification,

(B) The effective date of disqualification, and

(C) That all guaranteed association members and dependents shall be disenrolled and the final day of coverage provided by the program through the guaranteed association.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.626.1 to section 2699.6169 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6171. Continuation of Coverage Upon Disqualification of Guaranteed Association.

(a) If a guaranteed association is disqualified a member employer which meets the definition of sole employer set forth in Section 2699.6000 may continue coverage in the program without the sponsorship of a guaranteed association by notifying the program in writing of the member employer's change in status to sole employer. All member employees of the employer will become sole employees.

(b) Individual members shall not be continued in the program without the sponsorship of a qualified guaranteed association.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.626.15 to section 2699.6171 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6173. Disqualification of Member Employers.

(a) A member employer shall be disqualified from participation in the program if any of the following occur:

(1) Their guaranteed association is disqualified and the member employer does not change its status to sole employer pursuant to 2699.6171.

(2) It is found by the program pursuant to Section 2699.6119(b) to no longer be a qualified member employer.

(3) It is found by the program to no longer be in compliance with the participation requirements as set forth in Section 2699.6111.

(4) It fails to pay the monthly employer premium for the enrolled member employees and enrolled dependents as set forth in Sections 2699.6311 and 2699.6315 of this part.

(5) It so requests in writing. Such requests shall be provided to the program at least thirty (30) calendar days prior to the effective date of the requested disqualification.

(6) It has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program.

(b) When a participating member employer is disqualified pursuant to (a)(1), (a)(2), (a)(3), or (a)(4) above, the program shall notify the employer, each enrolled member employee and the qualified guaranteed association of the disqualification and the fact that all member employees and

dependents will be disenrolled. Notices sent to enrolled member employees shall be sent to their addresses of record.

(1) The notice shall be in writing and include the following information:

(A) The reason for the disqualification,

(B) The effective date of disqualification, and

(C) The final day of coverage provided through the program.

(2) When an employer is disqualified pursuant to (a)(4), the notice shall be sent after thirty-one (31) calendar days following the premium due date and also include a statement that the employer may again be qualified if the employer meets the requirements of Section 2699.6323 and a statement of the requirements of Section 2699.6323.

(c) An employer which is disqualified pursuant to (a)(1), (a)(2) or, (a)(3) above may reapply to the program whenever it again meets the requirements to be a qualified sole employer or it again meets the requirements to be a qualified member employer.

(d) An employer which is disqualified pursuant to (a)(5) or (a)(6) above, or an employer disqualified pursuant to (a)(4) above which does not reinstate pursuant to Section 2699.6319, cannot participate in the program for one (1) year from the date of disqualification.

(e) Member employees of member employers which are disqualified may apply to be individual members sponsored by a qualified guaranteed association if the individuals have not committed fraud or violated the program's rules to the detriment of the program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.626.2 to section 2699.6173 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).
2. Amendment of subsection (a)(2), new subsection (a)(3) and subsection renumbering, and amendment of subsections (b), (b)(2), (c) and (d) filed 5-5-97; operative 7-1-97 (Register 97, No. 19).

§ 2699.6175. Disqualification of Individual Members.

(a) An individual member shall be disqualified from participation in the program if any of the following occur:

(1) If the guaranteed association is disqualified.

(2) He or she is found by the program to no longer be a qualified individual member.

(3) The individual member fails to pay the monthly individual member premium for the enrolled individual member and enrolled dependents as set forth in Sections 2699.6311 and 2699.6313 of this part.

(4) The individual member so requests in writing. Such requests shall be provided to the program at least thirty (30) calendar days prior to the effective date of the requested disqualification.

(5) The individual member has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program.

(b) When a participating individual member is disqualified pursuant to (a) above, the program shall notify the individual member and the qualified guaranteed association of the disqualification.

(1) The notice shall be in writing and include the following information:

(A) The reason for the disqualification,

(B) The effective date of disqualification, and

(C) The final day of coverage provided through the program.

(2) When an individual member is disqualified pursuant to (a)(3), the notice shall be sent after thirty-one (31) calendar days following the premium due date and also include a statement that the individual member may again be qualified if the individual member meets the requirements of Section 2699.6462 and a statement of the requirements of Section 2699.6319.

(c) An individual member which is disqualified pursuant to (a)(2), (a)(4) or (a)(5) above, or is disqualified pursuant to (a)(3) above and does not reinstate pursuant to Section 2699.6319, cannot participate in the program for one (1) year from the date of disqualification.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.626.3 to section 2699.6175 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).

§ 2699.6176. Disqualification for Dental Benefits Coverage.

(a) A small employer or individual member shall be disqualified from participation in the dental benefits option in the program if any of the following occur:

(1) It is disqualified by the program pursuant to Sections 2699.6167, 2699.6173, or 2699.6175 from participation for health benefits coverage.

(2) The small employer or guaranteed association of an individual member fails to meet the requirements of Section 2699.6115

(3) It so requests in writing. Such requests shall be provided to the program in writing before the due date of the dental benefits premium.

(b) When a small employer or individual member is disqualified from participating for the dental benefits option, the small employer or individual member shall be notified in writing of the disqualification and effective date of the disqualification.

(c) A small employer or individual member disqualified pursuant to (a)(2) or (a)(3) above cannot participate for the dental benefits option for one year from the date of disqualification.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 5-23-94 as an emergency; operative 5-23-94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9-20-94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5-23-94 order transmitted to OAL 9-16-94 and filed 10-27-94 (Register 94, No. 43).

§ 2699.6177. Disenrollment of Sole Employees.

(a) Sole employees and their dependents, if any, shall be disenrolled from the program and from the program's participating carriers when any of the following occur:

(1) The enrolled sole employee's participating employer is disqualified from the program.

(2) The enrolled sole employee or dependents, if any, has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program or the rules of the participating carrier selected by the sole employee.

(3) The enrolled sole employee requests disenrollment through a participating employer of him or herself and the employee's dependents or the dependents only, either

(A) Because the sole enrollee or dependents have obtained coverage under another employer sponsored plan or,

(B) For any other reason.

(4) The employee ceases to be a sole employee of the participating employer. However, the former employee and the former employee's qualified dependents may continue in the program pursuant to Section 2699.6191, COBRA Benefits. The employer shall inform the program when an eligible sole employee ceases to be eligible by the end of the month in which the event occurs.

(5) A dependent ceases to be a dependent as defined in Section 2699.6000. The employer shall inform the program when an eligible dependent ceases to be eligible by the end of the month in which the event occurs.

(b) The program shall disenroll an enrollee pursuant to (a)(1) or (a)(2) above within sixty (60) calendar days of the program's determination to disenroll unless disenrollment is retroactive. If the program determines that an enrolled sole employee and/or dependent has committed an act of fraud or misrepresentation, the program may disenroll the employee and/or dependent as early as the date of the act of fraud or misrepresentation.

(c) To request to disenroll enrollees pursuant to (a)(3), (a)(4), or (a)(5) above, a participating employer shall notify the program of the full names, addresses, dates of birth, sex, and social security numbers of the enrollees to be disenrolled. If disenrolled pursuant to (a)(3), the effective date of the disenrollment shall be no later than 60 days from receipt of

the notice. Disenrollment will be no earlier than the end of the month in which notice is received. However, if notice is received by the first working day of a month, the disenrollment may be effective on the last day of the previous calendar month. If disenrolled pursuant to (a)(4) or (a)(5), the disenrollment shall be no later than 60 days from receipt of the request unless disenrollment is retroactive, in accordance with (d) below.

(d) If the program determines that an employee is or was not a qualified sole employee of a participating employer or a dependent is or was not a dependent of a sole employee, the program may disenroll the employee or dependent. The disenrollment may take place as early as the date the employee ceased being a sole employee or the dependent ceased being a dependent. If the program determines that the enrolled person never had qualifying status as a sole employee or dependent, the disenrollment may take place as early as that person's original effective date of coverage.

(e) A participating employer shall be notified by the program in writing of the disenrollment and effective date of disenrollment of a sole employee and/or dependents and the reason for the disenrollment.

(f) The program shall notify the participating carrier of the date of disenrollment.

(g) The sole employer's premium shall be adjusted, if applicable, as of the effective date of any disenrollment.

(h) If disenrolled pursuant to (a)(2) or (a)(3)(B) above, an individual sole employee and dependents, if any, shall not be eligible for enrollment in the program through the same participating employer for one year from the date of disenrollment. If disenrolled pursuant to (a)(3)(A), an employee or dependent who subsequently loses his or her coverage under another employer sponsored health plan can be re-enrolled in the program if the employee or dependent is otherwise eligible and applies for enrollment pursuant to Section 2699.6145 within thirty (30) calendar days of losing coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6261 to section 2699.6177 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (a)(4)–(5), (b)–(d), subsection relettering, and new subsection (g) filed 6–16–95 as an emergency; operative 6–16–95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–16–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 6–16–95 order transmitted to OAL 9–26–95 and filed 10–18–95 (Register 95, No. 42).

§ 2699.6181. Disenrollment of Member Employees and Dependents.

(a) Member employees and their dependents, if any, shall be disenrolled from the program and from the program's participating carriers when any of the following occur:

(1) The member employee's guaranteed association is disqualified. However, the member employee shall not be disenrolled if the member employer notifies the program that the member employer is changing to sole employer status.

(2) The enrolled member employee's participating employer is disqualified from the program.

(3) The enrolled member employee or dependents, if any, has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program or the rules of the participating carrier selected by the sole employee.

(4) The enrolled member employee requests disenrollment through a participating employer of him or herself and the member's dependents or the dependents only, either

(A) Because the enrollee or dependents have obtained coverage under another employer sponsored plan or,

(B) For any other reason.

(5) The employee ceases to be a member employee of the participating employer. However, the former employee and the former employee's qualified dependents may continue in the program pursuant to Section 2699.6191, COBRA Benefits. The employer shall inform the program when an eligible member employee ceases to be eligible by the end of the month in which the event occurs.

(6) A dependent ceases to be a dependent as defined in Section 2699.6000. The employer shall inform the program when an eligible dependent ceases to be eligible by the end of the month in which the event occurs.

(b) The program shall disenroll an enrollee pursuant to (a)(1) or (a)(2) or (a)(3) above within sixty (60) calendar days of the program's determination to disenroll unless disenrollment is retroactive. If the program determines that an enrolled member employee and/or dependent has committed an act of fraud or misrepresentation, the program may disenroll the employee and/or dependent as early as the date of the act of fraud or misrepresentation.

(c) To request to disenroll enrollees pursuant to (a)(4), (a)(5), or (a)(6) above, a participating employer shall notify the program of the full names, addresses, dates of birth, sex, and social security numbers of the enrollees to be disenrolled. If disenrolled pursuant to (a)(4), the effective date of the disenrollment shall be no later than 60 days from receipt of the notice. Disenrollment will be no earlier than the end of the month in which notice is received. However, if notice is received by the first working day of a month, the disenrollment may be effective on the last day of the previous calendar month. If disenrolled pursuant to (a)(5) or (a)(6) the disenrollment shall be no later than 60 days from receipt of the request unless disenrollment is retroactive, in accordance with (d) below.

(d) If the program determines that an employee is or was not a qualified member employee of a participating employer or a dependent is or was not a dependent of a member employee, the program may disenroll the employee or dependent. The disenrollment make take place as early as the date the employee ceased being a member employee or the dependent ceased being a dependent. If the program determines that the enrolled person never had qualifying status as a member employee or dependent, the disenrollment may take place as early as that person's original effective date of coverage.

(e) A participating member employer and the participating guaranteed association shall be notified by the program in writing of the disenrollment and effective date of disenrollment of an sole employee and/or dependents and the reason for the disenrollment.

(f) The program shall notify the participating carrier of the date of disenrollment.

(g) The member employer's premium shall be adjusted, if applicable, as of the effective date of any disenrollment.

(h) If disenrollment pursuant to (a)(3) or (a)(4)(B) above, an member employee and dependents, if any, shall not be eligible for enrollment in the program through the same participating employer for one (1) year from the date of disenrollment. If disenrolled pursuant to (a)(4)(A), an employee or dependent who subsequently loses his or her coverage under another employer sponsored health plan can be re-enrolled in the program if the employee or dependent is otherwise eligible and applies for enrollment pursuant to Section 2699.6147 within thirty (30) calendar days of losing coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6261.5 to section 2699.6181 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (a)(5)–(c), new subsection (d) and subsection relettering filed 6–16–95 as an emergency; operative 6–16–95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–16–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 6–16–95 order transmitted to OAL 9–26–95 and filed 10–18–95 (Register 95, No. 42).

§ 2699.6183. Disenrollment of Individual Members and Dependents.

(a) Individual members and their dependents, if any, shall be disenrolled from the program and from the program's participating carriers when any of the following occur:

(1) The individual member's participating guaranteed association is disqualified from the program.

(2) The individual member or dependents, if any, has committed an act of fraud or misrepresentation to circumvent the statutes or regulations of the program or the rules of the participating carrier selected by the individual member.

(3) The individual member requests disenrollment of him or herself and the individual member's dependents or the dependents only, either

(A) Because the enrollee or dependents have obtained coverage under another employer sponsored plan or,

(B) For any other reason.

(4) The individual member ceases to be a member of or sponsored for coverage by the participating guaranteed association. The individual member shall inform the program if the member ceases to be eligible by the end of the month in which the event occurs.

(5) A dependent ceases to be a dependent as defined in Section 2699.6000. The individual member shall inform the program when an eligible dependent ceases to be eligible by the end of the month in which the event occurs.

(b) The program shall disenroll an enrollee pursuant to (a)(1) or (a)(2) above within sixty (60) calendar days of the program's determination to disenroll unless disenrollment is retroactive. If the program determines fraud or misrepresentation, the program may disenroll the member and/or dependent as early as the date of the act of fraud or misrepresentation.

(c) To request to disenroll pursuant to (a)(3), (a)(4), or (a)(5) above, a participating individual member shall notify the program of the full names, addresses, dates of birth, sex, and social security numbers of the enrollees to be disenrolled. If disenrolled pursuant to (a)(3), the effective date of the disenrollment shall be no later than 60 days from receipt of the notice. Disenrollment will be no earlier than the end of the month in which notice is received. However, if notice is received by the first working day of a month, the disenrollment may be effective on the last day of the previous calendar month. If disenrolled pursuant to (a)(4) or (a)(5), the disenrollment shall be no later than 60 days from receipt of the request unless disenrollment is retroactive.

(d) If the program determines that an individual member is or was not a qualified individual member or a dependent is or was not a qualified dependent of the individual member, the program may disenroll the member or dependent. The disenrollment may take place as early as the date the individual member ceased being an individual member or dependent ceased being a dependent. If the program determines that the enrolled person never had qualifying status as an individual member or dependent, the disenrollment may take place as early as that person's original effective date of coverage.

(e) An individual member and the participating guaranteed association shall be notified by the program in writing of the disenrollment and effective date of disenrollment of an individual member and/or dependents and the reason for the disenrollment.

(f) The program shall notify the participating carrier of the date of disenrollment.

(g) The individual member's premium shall be adjusted, if applicable, as of the effective date of any disenrollment.

(h) If disenrollment pursuant to (a)(2) or (a)(3)(B) above, an individual member and dependents, if any, shall not be eligible for enrollment in the program for one (1) year from the date of disenrollment. If disenrolled pursuant to (a)(3)(A), an individual member or dependent who subsequently loses his or her coverage under an employer sponsored health plan can be re-enrolled in the program if the individual member or dependent is otherwise eligible and applies for enrollment pursuant to Section 2699.6149 within thirty (30) calendar days of losing coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6262.5 to section 2699.6183 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (a)(4)–(c), new subsection (d) subsection relettering and amendment of newly designated subsection (h) filed 6–16–95 as an emergency; operative 6–16–95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–16–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 6–16–95 order transmitted to OAL 9–26–95 and filed 10–18–95 (Register 95, No. 42).

§ 2699.6185. Discontinuance of Dental Benefits Coverage.

(a) Sole employees and individual members, and their dependents shall be discontinued from dental coverage under the following circumstances:

(1) The enrollee is disenrolled from health benefits coverage in the program.

(2) The participating employer of an eligible employee is disqualified for the dental benefits option.

(3) The guaranteed association of an individual member is disqualified for the dental benefits option.

(b) The final date of dental coverage shall be the last day for which the dental benefits premium is paid.

(c) Enrollees discontinued from dental coverage in the program pursuant to (a)(2) or (a)(3) above shall not be eligible for dental coverage for one year.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6187. Transfer of Enrollment for Sole and Member Employees.

(a) Other than transfers requested during an open enrollment period, an enrolled member or sole employee and enrolled dependents shall be transferred from one participating carrier to another if any of the following occurs:

(1) The participating employer so requests, in writing, because the employee has moved and no longer resides in an area served by the participating carrier in which the enrolled employee is enrolled, and there is at least one participating carrier serving the area in which the enrolled employee now resides.

(2) The participating employer so requests, in writing, on behalf of the employee, or the participating carrier so requests, in writing, because of failure to establish a satisfactory relationship between the enrolled employee or enrolled dependent and the participating carrier, and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating carrier serving the area in which the enrolled employee resides.

(b) Transfer of enrollment shall take effect within thirty (30) calendar days of approval of the request.

(c) The enrolled employee's participating employer and the affected participating carriers shall be notified in writing of any transfer of enrollment, and the effective date.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.627 to section 2699.6187 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6189. Transfer of Enrollment for Individual Members.

(a) Other than transfers requested during an open enrollment period, enrolled individual members and enrolled dependents shall be transferred from one participating carrier to another if any of the following occurs:

(1) The individual member so requests, in writing, because the individual member has moved and no longer resides in an area served by the par-

ticipating carrier in which the individual member is enrolled, and there is at least one participating carrier serving the area in which the individual member now resides.

(2) The individual member so requests, in writing, or the participating carrier so requests, in writing, because of failure to establish a satisfactory relationship between the individual member and the participating carrier, and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating carrier serving the area in which the individual member resides.

(b) Transfer of enrollment shall take effect within thirty (30) calendar days of approval of the request.

(c) The individual member and the affected participating carriers shall be notified in writing of any transfer of enrollment, and the effective date.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.627.5 to section 2699.6189 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6191. COBRA Benefits.

(a) Qualified small employers that have enrollees who qualify for extended coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended shall be permitted to obtain such coverage by notifying the program in writing of the enrollees' intent to obtain COBRA coverage and the information required by Section 2699.6177(c).

(b) The program shall notify the employer consistent with the requirements of COBRA of any necessary procedures for obtaining enrollee COBRA coverage within fifteen (15) calendar days of notification pursuant to (a) above.

(c) The COBRA eligible former employee will be individually billed and shall be responsible for making all premium payments pursuant to the same standards of payment for employers in Article 4 (Sections 2699.6300 et seq.) and the payment requirements of COBRA, for as long as the former employee and enrolled dependents remain eligible for COBRA coverage.

(d) Nothing in this part shall relieve any small employer or any participating carrier of their obligations as set forth in the Consolidated Omnibus Reconciliation Act of 1986 as amended.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6271 to section 2699.6191 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (b) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).

§ 2699.6193. Transfer of Enrollment for Dental Benefits.

(a) Other than transfers requested during an open enrollment period, an enrollee shall be transferred from one participating carrier to another if any of the following occurs:

(1) The participating employer on behalf of the employee, or the individual member, so requests, in writing, because the enrollee has moved and no longer resides in an area served by the participating dental benefits carrier in which the enrollee is enrolled, and there is at least one participating dental benefits carrier serving the area in which the enrollee now resides.

(2) The participating employer on behalf of the employee, or the individual member, so requests, in writing, or the participating dental benefits carrier so requests, in writing, because of failure to establish a satisfactory relationship between the enrollee and the participating dental benefits carrier, and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating dental carrier serving the area in which the enrolled employee resides.

(b) Transfer of enrollment for dental benefits shall take effect within 31 calendar days of approval of the request.

(c) The participating employer or individual member and the affected participating dental carrier shall be notified in writing of any transfer of enrollment, and the effective date.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6194. Payment to Insurance Agents and Brokers for Sole Employers.

(a) This subsection applies to sole employers who have an effective date of coverage prior to September 1, 1998 who have not made an election pursuant to Section 2699.6116.

(1) Except as specified in (2) below, the employer premium shall include an agent and broker fee if an insurance agent as defined in Section 31 of the Insurance Code or broker as defined in Section 33 of the Insurance Code assisted the sole employer in applying for the program, and if the sole employer is determined to be qualified as a result of the application, and the agent or broker requests such payment in writing as part of the application and includes his or her name, license number, tax identification number, and address.

(2) The employer premium shall include an agent or broker fee unless the sole employer's application includes the employer's certification that an agent or broker did not perform all of the following services:

(A) Assist the sole employer in completing the application,

(B) Calculate or determine the cost of program participation for the sole employer,

(C) Assist the sole employer in enrolling the sole employees of the sole employer.

(3) For sole employers who have made application to the program prior to July 1, 1996, the amount of the payment until the time of the qualified sole employer's first annual requalification pursuant to Section 2699.6117 shall be:

(A) For qualified sole employers that have, at the time of application, 2–25 enrollees, the payment shall be $50 for the sole employer per month and $4 per enrollee per month.

(B) For qualified sole employers that have 26–50 enrollees at the time of application the payment shall be $75 for the sole employer per month and $4 per enrollee per month.

(C) For qualified sole employers that have 51 or more enrollees at the time of application the payment shall be $100 for the sole employer per month and $4 per enrollee per month.

(4) For sole employers who have made application to the program on or after July 1, 1996, the amount of the payment until the time of the qualified sole employer's first annual requalification pursuant to Section 2699.6117 shall be:

(A) For qualified sole employers that have, at the time of the application, 2–9 enrollees, the payment shall be $50 for the sole employer per month and $4 per enrollee per month.

(B) For qualified sole employers that have, at the time of the application, 10–20 enrollees, the payment shall be $75 for the sole employer per month and $4 per enrollee per month.

(C) For qualified sole employers that have, at the time of the application, 21–30 enrollees, the payment shall be $100 for the sole employer per month and $4 per enrollee per month.

(D) For qualified sole employers that have, at the time of the application, 31–40 enrollees, the payment shall be $125 for the sole employer per month and $4 per enrollee per month.

(E) For qualified sole employers that have, at the time of the application, 41–50 enrollees, the payment shall be $150 for the sole employer per month and $4 per enrollee per month.

(F) For qualified sole employers that have, at the time of the application, 51 or more enrollees, the payment shall be $175 for the sole employer per month and $4 per enrollee per month.

(5)(A) Except as specified in (D) below, the sole employer premium shall continue to include an agent and broker fee after the employer's annual requalification pursuant to Section 2699.6117.

(B) For sole employers who had an effective date of coverage before July 1, 1997, the amount of the agent or broker fees after the time of the qualified sole employer's first annual requalification pursuant to Section 2699.6117 shall be as follows:

1. For qualified sole employers that have 2–25 enrollees at the time of application the payment shall be $30 for the sole employer per month and $4 per enrollee per month.

2. For qualified sole employers that have 26–50 enrollees at the time of application the payment shall be $40 for the sole employer per month and $4 per enrollee per month.

3. For qualified sole employers that have 51 or more enrollees at the time of application the payment shall be $50 for the sole employer per month and $4 per enrollee per month.

(C) For sole employers who had an effective date of coverage on or after July 1, 1997, the amount of the agent or broker fees after the time of the qualified sole employer's first annual requalification pursuant to Section 2699.6117 shall be as follows:

1. For qualified sole employers that have, at the time of the application, 2–9 enrollees, the payment shall be $30 for the sole employer per month and $4 per enrollee per month.

2. For qualified sole employers that have, at the time of the application, 10–20 enrollees, the payment shall be $50 for the sole employer per month and $4 per enrollee per month.

3. For qualified sole employers that have, at the time of the application, 21–30 enrollees, the payment shall be $70 for the sole employer per month and $4 per enrollee per month.

4. For qualified sole employers that have, at the time of the application, 31–40 enrollees, the payment shall be $80 for the sole employer per month and $4 per enrollee per month.

5. For qualified sole employers that have, at the time of the application, 41–50 enrollees, the payment shall be $100 for the sole employer per month and $4 per enrollee per month.

6. For qualified sole employers that have, at the time of the application, 51 or more enrollees, the payment shall be $115 for the sole employer per month and $4 per enrollee per month.

(D) The employer premium for an annual period shall normally include an agent or broker fee. However, such fees may be terminated commencing with the second year of enrollment for sole employers who made application to the program prior to July 1, 1996, and with the third year of enrollment for sole employers who applied on or after July 1, 1996 and had an effective date of coverage before July 1, 1997, if the sole employer's requalification request includes the employer's certification that an agent or broker provided neither of the following types of services:

1. Assist the sole employer in completing the requalification and/or assist the sole employer's enrollees with the open enrollment process pursuant to Section 2699.6139.

2. Assist the sole employer or enrollees in resolving enrollment, billing, claims or other program issues.

(6) The sole employer may redirect any payment made pursuant to this section to another agent or broker by submitting written notice signed by the employer to the program and providing the program with the information required under (a)(1) of this section. The effective date of the redirection shall be within ninety (90) calendar days following receipt of the notice.

(7) Payment to agents and brokers shall be terminated if one of the following occurs:

(A) The agent or broker is no longer a licensed agent or broker.

(B) The agent or broker materially violates any law or regulation regarding the sale of insurance or fails to comply with any court order.

(C) The agent or broker commits any willful or dishonest act resulting in injury to the program, a participating carrier, or an enrollee.

(8) For sole employers who apply on or after July 1, 1996, when agent or broker fees are terminated pursuant to (7)(A), (B) or (C) above within the first two years, the sole employer shall pay the equivalent monthly amount to the program as part of the program participation fee in accordance with Section 2699.6307, for the remainder of the first two years of enrollment.

(b) This subsection applies to sole employers who have an effective date of coverage on or after September 1, 1998 and sole employers who have made an election pursuant to Section 2699.6116.

(1) For sole employers who have an effective date of coverage on or after September 1, 1998 and sole employers who have made an election pursuant to Section 2699.6116, the amount of the agent or broker fee shall be an amount equal to eight percent of the comprehensive individual medical premium and comprehensive individual dental premium of each enrolling employee.

(2) If an insurance agent as defined in Section 31 of the Insurance Code or broker as defined in Section 33 of the Insurance Code assisted the sole employer in applying for the program, and if the sole employer is determined to be qualified as a result of the application, and the agent or broker requests such payment in writing as part of the application and includes his or her name, license number, tax identification number, and address, then the agent or broker fee shall be paid to the identified agent or broker.

(3) The sole employer may redirect any payment made pursuant to this section to another agent or broker by submitting a written notice signed by the employer to the program and providing the program with the information required under (2) of this section. The effective date of the redirection shall be within ninety (90) calendar days following receipt of the notice.

(4) Payment to agents and brokers shall be terminated if one of the following occurs:

(A) The agent or broker is no longer a licensed agent or broker.

(B) The agent or broker materially violates any law or regulation regarding the sale of insurance or fails to comply with any court order.

(C) The agent or broker commits any willful or dishonest act resulting in injury to the program, a participating carrier, or an enrollee.

(5) If the agent or broker fee is not directed to a particular agent or broker then the agent or broker fee shall be retained by the program as part of the program participation fee.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.628 to section 2699.6194 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsections (a)(2)(B), (c)(2), new subsections (c)(2)(A)–(C), and amendment of subsection (d) filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order including amendment of subsections (b)(1), (c)(2)(A) and (c)(2)(C) transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
4. Amendment filed 4–25–96; operative 5–25–96 (Register 96, No. 17).
5. Amendment of subsections (b)(1), (c)(2), and (d)(2) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).
6. Amendment filed 6–3–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 23).
7. Amendment filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
8. Editorial correction of subsection (b)(3) (Register 98, No. 47).

9. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6195. Payment to Insurance Agents and Brokers for Member Employers and Individual Members When Premiums Collected by Guaranteed Association.

(a) This subsection applies to guaranteed associations with an effective date of coverage prior to September 1, 1998 that have not made an election pursuant to Section 2699.6116.

(1) When the qualified guaranteed association collects the employer premium and individual member premium from the member employers and the individual members it shall be as follows:

(A) The guaranteed association may collect from its members and pay to agents as defined in Section 31 of the Insurance Code or brokers as defined in Section 33 of the Insurance Code an amount consistent with the policies and practices of the qualified guaranteed association.

(B) The employer premium or individual member premium shall include an agent or broker fee if the guaranteed association has elected to utilize the services of an agent or broker.

(b) This subsection applies to guaranteed associations with an effective date of coverage on or after September 1, 1998 and guaranteed associations who have made an election pursuant to Section 2699.6116.

(1) When the qualified guaranteed association collects the employer premiums and individual member premiums from the member employers and the individual members, the agent or broker fee shall be seven percent of the comprehensive individual medical premiums and comprehensive individual dental premiums for individual members and the agent or broker fee shall be eight percent of the comprehensive individual medical premiums and comprehensive individual dental premiums for member employers.

(2) The guaranteed association may designate an agent or broker as defined in Sections 31 and 33 of the Insurance Code to whom the agent or broker fee shall be paid.

(3) If the guaranteed association does not designate an agent or broker then the agent or broker fee shall be retained by the program as part of the program participation fee.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.628.5 to section 2699.6195 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 7–3–98 order transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6196. Payment to Insurance Agents and Brokers for Member Employers When Premium Collected by Program.

(a) This section applies to guaranteed associations with an effective date of coverage prior to September 1, 1998 that have not made an election pursuant to Section 2699.6116.

(1) Guaranteed associations may designate one or more insurance agents, as defined in Section 31 of the Insurance Code, or brokers, as defined in Section 33 of the Insurance Code, for guaranteed association members who participate in the program. When the program collects the employer premium from the member employers of the guaranteed association premium collection shall be as follows:

(A) Except as specified in (B) below, the employer premium shall include an agent and broker fee if a designated insurance agent or, if none is designated, any other insurance agent as defined in Section 31 of the Insurance Code or a designated broker or, if none was designated, any other insurance broker as defined in Section 33 of the Insurance Code assisted the member employer in applying for the program, and if the member employer is determined to be qualified as a result of the application, and the agent or broker requests such payment in writing as part of the application and includes his or her name, license number, tax identification number, and address.

(B) The employer premium shall include an agent or broker fee unless the member employer's application includes the member employer's certification that an agent or broker did not perform all of the following services:

1. Assist the member employer in completing the application,
2. Calculate or determine the cost of program participation for the member employer,
3. Assist the member employer in enrolling the sole employees of the member employer.

(C) For member employers who have made application to the program prior to July 1, 1996, the amount of the payment until the time of the qualified member employer's first annual requalification pursuant to Section 2699.6119 shall be:

1. For qualified member employers that have, at the time of application, 2–25 enrollees, the payment shall be $50 for the member employer per month and $4 per enrollee per month.
2. For qualified member employers that have 26–50 enrollees at the time of application the payment shall be $75 for the member employer per month and $4 per enrollee per month.
3. For qualified member employers that have 51 or more enrollees at the time of application the payment shall be $100 for the member employer per month and $4 per enrollee per month.

(D) For member employers who have made application to the program on or after July 1, 1996, the amount of the payment until the time of the member employer's first annual requalification pursuant to Section 2699.6119 shall be:

1. For qualified member employers that have, at the time of application, 2–9 enrollees, the payment shall be $50 for the member employer per month and $4 per enrollee per month.
2. For qualified member employers that have, at the time of application, 10–20 enrollees, the payment shall be $75 for the member employer per month and $4 per enrollee per month.
3. For qualified member employers that have, at the time of application, 21–30 enrollees, the payment shall be $100 for the member employer per month and $4 per enrollee per month.
4. For qualified member employers that have, at the time of application, 31–40 enrollees, the payment shall be $125 for the member employer per month and $4 per enrollee per month.
5. For qualified member employers that have, at the time of application, 41–50 enrollees, the payment shall be $150 for the member employer per month and $4 per enrollee per month.
6. For qualified member employers that have, at the time of application, 51 or more enrollees, the payment shall be $175 for the member employer per month and $4 per enrollee per month.

(E)1. Except as specified in (4) below, the member employer premium shall continue to include an agent and broker fee after the employer's annual requalification pursuant to Section 2699.6119.

2. For member employers who had an effective date of coverage before July 1, 1997, the amount of the agent or broker fees after the time of the qualified member employer's first annual requalification pursuant to Section 2699.6119 shall be as follows:

a. For qualified member employers that have, at the time of application 2–25 enrollees, the payment shall be $30 for the member employer per month and $4 per enrollee per month.

b. For qualified member employers that have 26–50 enrollees at the time of application the payment shall be $40 for the member employer per month and $4 per enrollee per month.

c. For qualified member employers that have 51 or more enrollees at the time of application the payment shall be $50 for the member employer per month and $4 per enrollee per month.

3. For member employers who had an effective date of coverage on or after July 1, 1997, the amount of the agent or broker fees after the time

of the qualified member employer's first annual requalification pursuant to Section 2699.6117 shall be as follows:

a. For qualified member employers that have, at the time of the application, 2–9 enrollees, the payment shall be $30 for the sole employer per month and $4 per enrollee per month.

b. For qualified member employers that have, at the time of the application, 10–20 enrollees, the payment shall be $50 for the sole employer per month and $4 per enrollee per month.

c. For qualified member employers that have, at the time of the application, 21–30 enrollees, the payment shall be $70 for the sole employer per month and $4 per enrollee per month.

d. For qualified member employers that have, at the time of the application, 31–40 enrollees, the payment shall be $80 for the sole employer per month and $4 per enrollee per month.

e. For qualified member employers that have, at the time of the application, 41–50 enrollees, the payment shall be $100 for the sole employer per month and $4 per enrollee per month.

f. For qualified member employers that have, at the time of the application, 51 or more enrollees, the payment shall be $115 for the sole employer per month and $4 per enrollee per month.

4. The employer premium for an annual period shall normally include an agent or broker fee. However, such fee may be terminated commencing with the second year of enrollment for member employers who made application to the program prior to July 1, 1996, and with the third year of enrollment for member employers who applied on or after July 1, 1996 and had an effective date of coverage before July 1, 1997, if the member employer's requalification request includes the employer's certification that an agent or broker provided neither of the following types of services:

a. Assist the member employer in completing the requalification and/or assist the member employer's enrollees with the open enrollment process pursuant to Section 2699.6139.

b. Assist the member employer or enrollees in resolving enrollment, billing, claims or other program issues.

(F) The member employer may redirect any payment made pursuant to this section to another designated agent or broker or, if none is designated, any agent or broker, by submitting written notice signed by the employer to the program and providing the program with the information required under (a)(1)(A) of this section. The effective date of the redirection shall be within ninety (90) calendar days following receipt of the notice.

(G) Payment to agents and brokers shall be terminated if one of the following occurs:

1. The agent or broker is no longer a licensed agent or broker.

2. The agent or broker materially violates any law or regulation regarding the sale of insurance or fails to comply with any court order.

3. The agent or broker commits any willful or dishonest act resulting in injury to the program, a participating carrier, or an enrollee.

(H) For member employers who apply on or after July 1, 1996, when agent or broker fees are terminated pursuant to (G)(1), (2), or (3) above within the first two years, the member employer shall pay the equivalent monthly amount to the program as part of the program participation fee in accordance with Section 2699.6307, for the remainder of the first two years of enrollment.

(b) This subsection applies to guaranteed associations with an effective date of coverage on or after September 1, 1998 and guaranteed associations that have made an election pursuant 2699.6116.

(1) This section applies to guaranteed associations with effective dates of coverage on or after September 1, 1998 and guaranteed associations that have made an election pursuant to Section 2699.6116. For member employers of such guaranteed associations, the amount of the agent or broker fee shall be eight percent of the comprehensive individual medical premiums and comprehensive individual dental premiums.

(2) Guaranteed associations may designate one or more insurance agents, as defined in Section 31 of the Insurance Code, or brokers, as defined in Section 33 of the Insurance Code, for guaranteed association members who participate in the program.

(3) If a designated agent or broker, or if none is designated, any other insurance agent as defined in Section 31 of the Insurance Code or broker as defined in Section 33 of the Insurance Code assisted the member employer in applying for the program, and if the member employer is determined to be qualified as a result of the application, and the agent or broker requests such payment in writing as part of the application and includes his or her name, license number, tax identification number, and address then the agent or broker fee shall be paid to the identified agent or broker.

(4) The member employer may redirect any payment made pursuant to this section to another designated agent or broker, or if none is designated, any other agent or broker, by submitting a written notice signed by the member employer to the program and providing the program with the information required under (b)(3) of this section. The effective date of the redirection shall be within ninety (90) calendar days following receipt of the notice.

(5) Payment to agents and brokers shall be terminated if one of the following occurs:

(A) The agent or broker is no longer a licensed agent or broker.

(B) The agent or broker materially violates any law or regulation regarding the sale of insurance or fails to comply with any court order.

(C) The agent or broker commits any willful or dishonest act resulting in injury to the program, a participating carrier, or an enrollee.

(6) If the agent or broker fee is not directed to a particular agent or broker then the agent or broker fee shall be retained by the program as part of the program participation fee.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.628.6 to section 2699.6196 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order including amendment of subsections (a)(1), (a)(3)(A) and (a)(4)(B)1. transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
4. Amendment filed 4–25–96; operative 5–25–96 (Register 96, No. 17).
5. Amendment of subsections (a)(3)(A), (a)(4)(A) and (a)(5)(B)1. filed 5–5–97; operative 7–1–97 (Register 97, No. 19).
6. Amendment filed 6–3–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 23).
7. Amendment filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
8. Editorial correction of subsection (a)(1)(E)1. (Register 98, No. 47).
9. Certificate of Compliance as to 7–3–98 order, including amendment of subsections (a)(1)(F) and (b)(4), transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6197. Payment to Insurance Agents and Brokers for Individual Members When Premium Collected by Program.

(a) This section applies to guaranteed associations with an effective date of coverage prior to September 1, 1998 that have not made an election pursuant to Section 2699.6116.

(1) Guaranteed associations may designate one or more insurance agents, as defined in Section 31 of the Insurance Code, or brokers, as defined in Section 33 of the Insurance Code, for guaranteed association members who participate in the program. When the program collects the individual member premium from the individual members it shall be as follows:

(A) Except as specified in (B) below, the individual member premium shall include an agent and broker fee if a designated insurance agent or, if none is designated, any other insurance agent as defined in Section 31 of the Insurance Code or a designated broker or, if none was designated, any other insurance broker as defined in Section 33 of the Insurance Code

assisted the individual member in applying for the program, and if the individual member is determined to be qualified as a result of the application, and the agent or broker requests such payment in writing as part of the application and includes his or her name, license number, tax identification number, and address.

(B) The individual member premium shall include an agent or broker fee unless the individual member's application includes the individual member's certification that an agent or broker did not perform all of the following services:

1. Assist the individual member in completing the application,

2. Calculate or determine the cost of program participation for the individual member.

(C) The amount of the payment until the time of the qualified individual member's first annual requalification pursuant to Section 2699.6119 of this part shall be:

1. For qualified individual members the payment shall be $14 for the individual member per month and $4 per enrolled dependent per month.

(D)1. Except as specified in (3) below, the individual member premium shall continue to include an agent and broker fee after the individual member's annual requalification pursuant to Section 2699.6119.

2. The amount of the fee after the time of the qualified individual member's first annual requalification pursuant to Section 2699.6119 shall be $9 for the individual member and $4 for each enrolled dependent per month.

3. The individual member premium for an annual period shall normally include an agent or broker fee. However, such fee may be terminated commencing with the second year of enrollment for individual member who made application to the program prior to July 1, 1996 and with the third year of enrollment for individual members who applied on or after July 1, 1996 and had an effective date of coverage before July 1, 1997, if the individual member requalification request includes the member's certification that the agent or broker provided neither of the following types of services:

i. Assist the individual member in completing the requalification and/or assist the individual member with the open enrollment process pursuant to Section 2699.6139.

ii. Assist the individual member resolving enrollment, billing, claims or other program issues.

(E) The individual member may redirect any payment made pursuant to this section to another designated agent or broker or, if none is designated, any agent or broker by submitting written notice signed by the individual member to the program and providing the program with the information required under (a)(1) of this section. The effective date of the redirection shall be within ninety (90) calendar days following receipt of the notice.

(F) Payment to agents and brokers shall be terminated if one of the following occurs:

1. The agent or broker is no longer a licensed agent or broker.

2. The agent or broker materially violates any law or regulation regarding the sale of insurance or fails to comply with any court order.

3. The agent or broker commits any willful or dishonest act resulting in injury to the program, a participating carrier, or an enrollee.

(G) For individual members who apply on or after July 1, 1996, when agent or broker fees are terminated pursuant to (F)(1), (2), or (3) above within the first two years, the individual member shall pay the equivalent amount monthly to the program as part of the program participation fee in accordance with Section 2699.6307 for the remainder of the first two years of enrollment.

(b) This subsection applies to guaranteed associations with an effective date of coverage on or after September 1, 1998 and guaranteed associations that have made an election pursuant 2699.6116.

(1) This section applies to guaranteed associations with effective dates of coverage on or after September 1, 1998 and guaranteed associations that have made an election pursuant to Section 2699.6116. For individual members of such guaranteed associations, the amount of the agent or broker fee shall be seven percent of the comprehensive individual medical premiums and comprehensive individual dental premiums.

(2) Guaranteed associations may designate one or more insurance agents, as defined in Section 31 of the Insurance Code, or brokers, as defined in Section 33 of the Insurance Code, for guaranteed association members who participate in the program.

(3) If a designated agent or broker, or if none is designated, any other insurance agent as defined in Section 31 of the Insurance Code or broker as defined in Section 33 of the Insurance Code assisted the individual member in applying for the program, and if the individual member is determined to be qualified as a result of the application, and the agent or broker requests such payment in writing as part of the application and includes his or her name, license number, tax identification number, and address then the agent or broker fee shall be paid to the identified agent or broker.

(4) The individual member may redirect any payment made pursuant to this section to another designated agent or broker, or if none is designated, any other agent or broker, by submitting a written notice signed by the individual member to the program and providing the program with the information required under (b)(3) of this section. The effective date of the redirection shall be within ninety (90) calendar days following receipt of the notice.

(5) Payment to agents and brokers shall be terminated if one of the following occurs:

(A) The agent or broker is no longer a licensed agent or broker.

(B) The agent or broker materially violates any law or regulation regarding the sale of insurance or fails to comply with any court order.

(C) The agent or broker commits any willful or dishonest act resulting in injury to the program, a participating carrier, or an enrollee.

(6) If the agent or broker fee is not directed to a particular agent or broker then the agent or broker fee shall be retained by the program as part of the program participation fee.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.628.7 to section 2699.6197 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12–29–94 order including amendment of subsections (a)(1) and (a)(4)(A)–(B) transmitted to OAL 4–12–95 and filed 5–22–95 (Register 95, No. 21).
4. Amendment of subsections (a)(4)(A)–(C) and new subsection (a)(7) filed 4–25–96; operative 5–25–96 (Register 96, No. 17).
5. Amendment of subsections (a)(4)(C) and (a)(4)(C)1., repealer and new subsection (a)(4)(C)2., and repealer of subsection (a)(4)(C)3. filed 6–3–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 23).
6. Amendment filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 7–3–98 order, including amendment of subsection (b)(4), transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6198. Payment to Insurance Agents and Brokers for Dental Benefits.

(a) If the employer premium or individual member premium includes an agent or broker fee pursuant to the provisions of Sections 2699.6194, 2699.6196, and 2699.6197, the employer premium or the individual member premium shall include an additional $1.00 per month agent or broker fee for each enrollee receiving dental coverage in the program.

(b) An employer premium or individual member premium paid as described in Section 2699.6195 shall include an agent or broker fee for the dental benefits option as determined by the qualified guaranteed association.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

History

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

Article 3. Benefits

§ 2699.6200. Scope of Benefits.

(a) The basic scope of benefits offered by participating carriers as a health benefits plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6203. No other benefits shall be permitted to be offered by a participating carrier. The basic scope of benefits shall be as follows:

(1) Those benefits described in Section 1300.67 of Title 10 of the California Code of Regulations.

(2) Plastic and reconstructive surgical services limited to the following:

(A) Surgery to correct a physical functional disorder resulting from a disease or congenital anomaly.

(B) Surgery to correct a physical functional disorder following either an injury or incidental to any other surgery.

(C) Reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury, and internal breast prosthesis required incidental to the surgery.

(3) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration, generic equivalents approved as substitutable by the federal Food and Drug Administration, or drugs approved by the federal Food and Drug Administration as Treatment Investigational New Drugs or classified as Group C cancer drugs by the National Cancer Institute to be used only for the purposes approved by the federal Food and Drug Administration or the National Cancer Institute.

(4) Mental Health benefits, limited to the following:

(A) Inpatient care in a health facility licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code (Section 1250 et seq.), for a total of ten (10) days in each benefit year,

1. Residential treatment may be substituted for inpatient care days at a ratio of two (2) residential treatment days to one (1) inpatient day, and

2. Intensive outpatient treatment may be substituted for inpatient care days at a ratio of three (3) intensive outpatient days to one (1) inpatient day.

(B) Twenty (20) outpatient visits in each benefit year.

(5) Outpatient medical rehabilitation and the outpatient services of occupational therapists, physical therapists, and speech therapists for treatment of acute conditions or the acute phase of chronic conditions if such conditions are subject to continuing significant improvement within a period of two (2) months.

(6) Durable medical equipment, prosthetic devices, orthotic devices and oxygen and oxygen equipment, limited to equipment and devices which:

(A) are intended for repeated use over a prolonged period,

(B) are not considered disposable, with the exception of ostomy bags,

(C) are ordered by a licensed health care provider acting within the scope of his or her license,

(D) are intended for the exclusive use of the enrollee,

(E) do not duplicate the function of another piece of equipment or device covered by the carrier for the enrollee,

(F) are generally not useful to a person in the absence of illness or injury,

(G) primarily serve a medical purpose, and

(H) are appropriate for use in the home.

Medically necessary repair or replacement of covered durable medical equipment, prosthetic devices, and orthotic devices is a benefit when prescribed by a physician or ordered by a licensed health care provider acting within the scope of his or her license, and when not caused by misuse or loss.

(7) Human organ transplants, including reasonable medical and hospital expenses of a donor or individual identified as a prospective donor if the expenses are directly related to the transplant, other than corneal, shall be subject to the following restrictions:

(A) Preoperative evaluation, surgery, and follow–up care shall be provided at centers that have been designated by the participating carrier as having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.

(B) Patients shall be selected by the patient–selection committee of the designated centers and subject to prior authorization.

(C) Only anti–rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

(8) Chemical dependency and alcoholism benefits, limited to the following:

(A) Detoxification of chemical dependency or alcohol abuse,

(B) Outpatient treatment limited, at the participating carrier's discretion, to either of the following:

1. A maximum payment of $20 per day, and a maximum payment of $400 per person for all outpatient chemical dependency and alcoholism benefits in each benefit year, or

2. Alternative arrangements that have been approved by the program and are described in the carrier's evidence of coverage document.

(9) Hospice care when a participating health plan determines it is a less costly alternative to other of the basic minimum benefits.

(10) Home health care and home health services as described in Section 1374.10(b) of the California Health and Safety Code. This does not preclude a carrier from providing other health care benefits in the home.

(11) Supplies, equipment, and services for the treatment and/or control of diabetes, even when such items, tests and services are available without a prescription, including:

(A) Supplies and equipment such as:

1. insulin,
2. syringes,
3. lancets,
4. insulin pumps and all related necessary supplies,
5. ketone urine testing strips for type I diabetes,
6. blood glucose meters, and
7. blood glucose meter testing strips in medically appropriate quantities for:

a. the monitoring and treatment of insulin dependent diabetes

b. the monitoring and treatment of non–insulin dependent diabetes

c. the monitoring and treatment of diabetes in pregnancy

(B) Diabetes education programs,

(C) Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A–1C (Glycohemogolobin), and

(D) Dilated retinal eye exam

(12) Short–term skilled nursing care provided in a skilled nursing facility or a skilled nursing bed in an acute care hospital, limited to a maximum of sixty (60) days in each benefit year.

This benefit does not cover conditions which are long–term or chronic in nature and require ongoing inpatient skilled nursing care, other than care for an acute phase of such a condition, or care at the inception of such a condition which is appropriate for stabilization prior to release from inpatient care.

(13) This part shall not be construed to prohibit a plan's ability to impose cost–control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

(14) Nothing in this section shall preclude the direct reimbursement of physician assistants, nurse practitioners or other advanced practice nurses who provide covered services within their scope of licensure.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Relocation of article heading and renumbering of former section 2699.630 to section 2699.6200 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of subsection (a) filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
4. Amendment of subsection (a)(6), new subsections (a)(6)(A)–(H), (a)(10)–(12) and subsection renumbering filed 5–8–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6201. Scope of Dental Benefits.

(a) The basic scope of benefits offered by a participating dental carrier as a dental benefit plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6205. No other dental benefits shall be permitted to be offered by a participating dental carrier. The basic scope of dental benefits shall be as follows:

(1) Diagnostic and Preventive Benefits

(A) Initial, periodic and emergency oral examinations, limited as follows:

1. Routine oral examinations: one every six months per enrollee.

(B) Palliative treatment.

(C) Consultations, including specialist consultations.

(D) Roentgenology, limited as follows:

1. Bitewing x–rays in conjunction with period examinations are limited to one series of four films in any 12 consecutive month period.

2. Full mouth x–rays in conjunction with period examinations are limited to once every 60 consecutive months.

3. Panoramic film x–rays are limited to once every 60 consecutive months.

4. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

(E) Prophylaxis services, limited as follows:

1. Not to exceed once in a six month period.

(F) Fluoride treatment, limited as follows:

1. Only for dental benefit plan enrollees under the age of 18.

2. One every 12 months.

(G) Dental sealant treatments, limited as follows:

1. Only for dental plan enrollees under the age of 14.

2. Permanent first and second molars only.

3. One treatment per tooth in a 36 consecutive month period.

(H) Space maintainers, limited as follows:

1. Only for dental plan enrollees under the age of 14.

(I) Preventive dental education and oral hygiene instruction

(J) Study models

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly alternative is chosen by the patient, the patient will be responsible for all additional charges.

2. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is necessary for the enrollee's dental health.

(B) Use of pins in conjunction with a restoration.

(3) Oral Surgery

(A) Extractions, including surgical extractions

(B) Removal of impacted teeth, limited as follows:

1. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus if interfering with a prosthesis

(G) Treatment of mandibular torus if interfering with a prosthesis

(H) Frenulectomy

(I) Incision and drainage of abscesses

(J) Post–operative services including exams, suture removal and treatment of complications.

(4) Endodontics

(A) Direct pulp capping

(B) Therapeutic pulpotomy

(C) Apexification filling with calcium hydroxide

(E) Root amputation and Hemisection

(F) Root canal therapy

(G) Apicoectomy

(H) Retrograde filling

(I) Vitality tests

(5) Periodontics

(A) Periodontal scaling performed in the presence of gingival inflammation

(B) Periodontal scaling and root planing, gingival flap procedure, and subgingival curettage, limited as follows:

1. Four quadrant treatments in any 12 consecutive months.

(C) Gingivectomy or gingivoplasty

(D) Osseous or muco–gingival surgery

(E) Correction of occlusion, limited to occlusal adjustment.

(6) Crowns and Fixed Bridges

(A) Crowns, limited as follows:

1. Replacement of each unit is limited to once every 60 consecutive months, with the exception of prefabricated stainless steel crowns.

(B) Fixed bridges, limited as follows:

[The next page is 754.41.]

1. Fixed bridges are a covered benefit when there are one or two missing teeth in any one quadrant.

2. Other than in one (1) above, fixed bridges will be covered only when a partial denture cannot satisfactorily restore the case. If a fixed bridge is used when a partial could satisfactorily restore the case, coverage will be provided at the level it would have been for a partial denture.

3. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

4. Replacement of bridge pontic and bridge abutment units is limited to once every 60 consecutive months.

(C) Recementation of crowns or bridges

(D) Inlays and onlays, limited as follows:

1. Replacement of each unit is limited to once every 60 consecutive months.

(E) Prefabricated, cast or laboratory posts and cores for crowns or bridges

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full or partials, teeth, and clasps, limited as follows:

1. Partial dentures are not to be replaced within 60 consecutive months, unless:

a. it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or

b. the denture is unsatisfactory and cannot be made satisfactory.

2. Full upper and/or lower dentures are not to be replaced within 60 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory.

3. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.

4. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited as follows:

1. One per arch in any 24 consecutive months for a standard procedure.

2. One per arch may be performed during the 6 consecutive months after an immediate procedure. After this initial period, this benefit is limited to one per arch in any 24 consecutive months.

(C) Denture repair

(D) Denture adjustment

(E) Tissue conditioning

(8) Orthodontia

(A) The basic benefit shall cover a treatment program and shall include:

1. Start–up records, examination, consultation, x–rays, study models, photographs.

2. Final exam, x–rays, study models, photographs.

3. Post–treatment retention

(B) Interceptive orthodontic treatment shall be a benefit if, in the opinion of the dental professional and the dental carrier, alternative interceptive orthodontic treatment would be a more appropriate course of treatment for an enrollee under the age of 18 than the customary orthodontic program described in (A) above.

(9) Other Dental Benefits

(A) Local anesthetics.

(B) Injection of antibiotic drugs.

(10) This part shall not be construed to prohibit a dental plan's ability to impose cost–control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(11) The level of benefits covered under a fee–for–service dental benefit plan shall be limited to usual, customary or reasonable (UCR) charges.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
3. Editorial correction of subsection (a)(7)(A)4 (Register 94, No. 43).

§ 2699.6203. Excluded Health Benefits.

(a) Health benefits plans offered under this program shall exclude the following benefits:

(1) Services, supplies, items, procedures or equipment which are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a less costly facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage.

(3) Custodial, domiciliary care, or rest cures for which facilities and/or services of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self–administered.

(4) Personal or comfort items or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:

(A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or

(B) Outmoded or not efficacious.

(7) Transportation except as specified in Section 1300.67(g) of Title 10 of the California Code of Regulations.

(8) Implants, except those that are medically necessary and are neither cosmetic, experimental, or investigational.

(9) Sex change operations, reversal of voluntary sterilization, conception by artificial means, and non–prescription contraceptive supplies and devices.

(10) Eye glasses, contact lenses, routine eye examinations (including eye refractions) except when provided as part of routine examination under preventive care for minors, hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care.

(11) Long–term care benefits, including long–term skilled nursing care in a licesed facility and respite care are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits. This section does not exclude short–term skilled nursing care benefits as provided pursuant to Section 2699.6200(a)(12).

(12) Dental Services and dental appliances.

(13) Treatment of obesity by medical and surgical means, except for treatment of morbid obesity. In no instance shall treatment for morbid obesity be provided primarily for cosmetic reasons.

(14) Cosmetic surgery, except as specifically provided in Section 2699.6200(a)(2).

(15) Conditions resulting from acts of war (declared or not).

(16) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan.

(b) A health benefit plan with a point of service option that is offered by a health maintenance organization or a health benefit plan with a point of service option that is offered by an exclusive provider organization may exclude the following benefits and services when the enrollee receives them from providers who do not contract with the health maintenance organization or exclusive provider organization or when the enrollee receives them in violation of the health benefit plan's established procedures:

(1) outpatient prescription drugs,

(2) human organ transplants,

(3) treatment for infertility, including tests,

(4) mental health benefits,

(5) outpatient chemical dependency and alcoholism benefits,

(6) preventive and health education services.

(c) A health benefit plan with a point of service option that is offered by a health maintenance organization or a health benefit plan with a point of service option that is offered by an exclusive provider organization may exclude coverage for durable medical equipment prescribed by a provider who does not contract with the health maintenance organization or exclusive provider organization. However, if the prescription is obtained in accordance with established health plan procedures coverage shall not be excluded.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.631 to section 2699.6203 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment of section heading and new subsections (b)–(c) filed 5–2–96; operative 6–1–96 (Register 96, No. 18).
3. Amendment of subsections (a)(1), (a)(11) and (b)(3) filed 5–8–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6205. Excluded Dental Benefits.

(a) Dental benefits plans offered under this program shall exclude the following benefits:

(1) Procedures, treatment or products which are not necessary for the patient's dental health. Procedures, treatments, or products are considered necessary for the patient's dental health if they are not investigational and are necessary because:

(A) They are appropriate and are provided in accordance with accepted dental care standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of dental care rendered; and

(B) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(C) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any procedure, service, product, treatment, or drug which is either:

(A) Experimental or investigational or which is not recognized in accord with generally accepted dental care standards as being safe and effective for use in the treatment in question, or

(B) Outmoded or not efficacious.

(3) Treatment for any dental condition arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan.

(4) Services related to acts of war, or needed while in the service of the armed forces of any country.

(5) Treatments or services provided by persons other than licensed dentists or licensed dental professionals practicing under the supervision of a licensed dentist.

(6) Dispensing of drugs which are not normally supplied in dental offices.

(7) Hospital charges of any kind.

(8) Treatment by any method of any condition of the temporomandibular joint.

(9) Elective or cosmetic dentistry. This includes personalization or characterization of dentures, porcelain veneers on molar teeth, and tooth color restorations on molar teeth, but does not include porcelain veneers on other teeth and tooth color restorations on other teeth.

(10) Oral surgery requiring the setting of fractures or dislocations.

(11) Orthognathic surgery.

(12) Removable orthodontic appliances, and fixed or removable orthodontic retainers, except as provided in the retention phase of the orthodontic benefit.

(13) The replacement of fixed prosthodontics and removable prosthetic devices that are rendered nonfunctional due to patient abuse, misuse, or neglect.

(14) Replacement of prosethetic devices such as full or partial dentures due to loss or theft.

(15) General anesthesia, intravenously administered conscious sedation, or other conscious sedation including nitrous oxide.

(16) Any procedure performed for the purpose of achieving full mouth occlusal equilibration to alter the bite.

(17) Services or supplies solely to increase vertical dimension. These may include dentures, crowns, inlays and onlays, fixed bridges or any other appliance or service.

(18) Services related to or treatment of malignancies, with the exception of biopsies.

(19) Treatment of congenital malformations.

(20) Tooth replantation.

(21) Supplies used for self–administered services or treatments which are related to dietary counseling, oral hygiene, plaque control, chemical analysis, or saliva.

(22) Implants and the removal of implants are not covered benefits. However, if implants are determined to be less a costly alternative to a covered benefit by the dental carrier, they may be provided pursuant to Subsection 2699.6201(a)(10). Removal of an implant provided as a less costly alternative is a covered benefit. Replacement of an implant provided as a less costly alternative is limited to once every 60 consecutive months.

(23) Restorations provided pursuant to Subsection 2699.6201(a)(2) utilizing gold, porcelain, and restorative materials other than amalgam or like materials are not covered benefits except as specified in Subsection 2699.6201(a)(2)(A)(1).

(24) Grafting tissues from outside the mouth to tissue inside the mouth.

(25) Services which are benefits under the medical insurance portion of the program.

(26) For benefits received under fee–for–service dental benefit plans, all charges exceeding those considered usual, customary or reasonable.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6205 to section 2699.6103 and new section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted with amendment of subsection (a)(21) to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

3. Amendment of subsection (a)(23) filed 10–18–95; operative 10–18–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 42).

§ 2699.6207. Administration of Benefits.

A participating carrier shall administer each of its health benefits plans pursuant to the carrier's administrative procedures, medical protocols and medical review criteria and procedures.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.632 to section 2699.6207 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6209. Enrollee Share of Cost For Health Benefits.

Every participating carrier shall require copayments and deductibles for health benefits provided to enrollees subject to the following:

(a) For enrollees in health maintenance organizations, exclusive provider organizations, preferred provider organizations, health maintenance organizations with a point of service option, and exclusive provider organizations with a point of service option, the sum of the in–network copayments and deductibles shall not exceed $2,000 in a benefit year for an enrollee or $4,000 in a benefit year for an enrolled sole employee and enrolled dependents or for a guaranteed association member and enrolled dependents for covered benefits and services provided by a provider who contracts with the carrier to provide health care benefits and services. In any benefit year that an enrollee has paid the maximum copayments described in Section 2699.6209(b)(4)(B)(1)(a) or Section 2699.6209(b)(4)(D)(1)(a), the enrollee shall be deemed to have met the maximum in –network copayment requirement described in this section. For enrollees in indemnity plans the sum of all copayments and deductibles shall not exceed $2,000 in a benefit year for an enrollee or $4,000 in a benefit year for an enrolled sole employee and enrolled dependents or for a guaranteed association member and enrolled dependents for covered benefits and services.

(b) Participating carriers shall offer two options for enrollee share of cost: a standard option and a preferred option.

(1) In the case of participating carriers which are health maintenance organizations or exclusive provider organizations:

(A) A preferred option shall consist of the following elements:

1. A $5 copayment per visit for office or home visits, with the following exceptions:

a. treatment for infertility, including tests, shall be subject to a copayment of 50% of the carrier's contracted or scheduled rate of payment, and

b. outpatient mental health visits shall be subject to a $20 per visit copayment;

2. A $10 copayment per outpatient prescription for up to a 31 day supply of a prescription drug. A $10 copayment shall apply to additional supplies of the prescription in up to 31 day increments. However this amount shall be $5 per prescription for up to a 31 day supply of a prescription drug when a generic prescription drug is utilized or when a participating carrier has a mandatory generic prescription drug substitution program which has been approved by the program. A $5 copayment shall apply to additional supplies of such a prescription in up to 31 day increments.

An exception to the above is that a $20 copayment per prescription shall apply for a 90 day supply of a prescription drug. However, this amount shall be $10 per prescription for a 90 day supply of a generic prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program.

3. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital.

(B) A standard option shall consist of the following elements:

1. A $15 copayment per visit for office or home visits, with the following exceptions:

a. treatment for infertility, including tests, shall be subject to a copayment of 50% of the carrier's contracted or scheduled rate of payment; and

b. visits for prenatal care and pediatric visits up to the age of two (2) will be subject to a $5 copayment per visit; and

c. outpatient mental health visits shall be subject to a $20 per visit copayment;

2. A $15 copayment per outpatient prescription for up to a 31 day supply of a prescription drug. A $15 copayment shall apply to additional supplies of the prescription in up to 31 increments. However this amount shall be $10 per prescription for up to a 31 day supply of a prescription drug when a generic prescription drug is utilized or when a participating carrier has a mandatory generic prescription drug substitution program which has been approved by the program. A $10 copayment shall apply to additional supplies of such a prescription in up to 31 day increments.

An exception to the above is that a $30 copayment per prescription shall apply for a 90 day supply of a prescription drug. However, this amount shall be $20 per prescription for a 90 day supply of a generic prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program.

3. A $100 copayment for each hospital or skilled nursing facility admission; and

4. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital.

(2) In the case of participating carriers which are preferred provider organizations:

(A) A preferred option shall consist of the following elements:

1. A copayment which shall be 20% of the contracted rate for covered benefits and services provided by a provider who contracts with the preferred provider organization to provide health care benefits and services other than outpatient prescription drugs, with the following exceptions:

a. treatment for infertility (including tests) provided by a provider who contracts with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's contracted rate of payment, and

b. outpatient mental health visits provided by a provider who contracts with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's contracted rate of payment, and

c. visits for prenatal care and pediatric visits up to the age of two for covered benefits and services provided by a provider who contracts with the preferred provider organization to provide health care benefits and services will not be subject to a copayment.

2. A copayment which shall be 40% of the scheduled rate of payment established by the participating carrier for covered benefits and services provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services, with the following exceptions:

a. treatment for infertility (including tests) provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's scheduled rate of payment.

b. outpatient mental health visits provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's scheduled rate of payment.

c. the copayments described in 2., 2.a. and 2.b. above shall be limited to $5,000 in a benefit year for an enrollee or $10,000 in a benefit year for an enrolled sole employee and dependents or guaranteed association members and dependents.

d. enrollees are responsible for 100% of the charges in excess of the carrier's scheduled rate of payment for health care benefits and services provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services. These amounts are not subject to the limitations in 2.c. on copayment expenses.

3. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital;

4. A copayment which shall be 30% of the contracted rate for prescription drugs provided by a provider who contracts with the preferred provider organization to provide prescription drugs. However this amount shall be 20% when a generic prescription drug is utilized or when a participating carrier has a mandatory generic prescription drug substitution program which has been approved by the program; and a copayment equivalent to that for a 60 day supply of a prescription shall apply to a 90 day supply of the same prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program; and

5. A deductible which shall be $250 per enrollee in a benefit year. The deductible may be reduced by an amount equal to the amount an enrollee with qualifying prior coverage paid toward a deductible under the qualifying prior coverage for services rendered within the 90 days immediately prior to the enrollee's effective date of enrollment in the program. Such reduction may only be applied for the first full or partial benefit year that the enrollee is enrolled in the program.

(B) A standard option shall consist of the following elements:

1. A copayment which shall be 20% of the contracted rate for covered benefits and services provided by a provider who contracts with the preferred provider organization to provide health care benefits and services other than outpatient prescription drugs, with the following exceptions:

a. treatment for infertility (including tests) provided by a provider who contracts with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's contracted rate of payment, and

b. outpatient mental health visits provided by a provider who contracts with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's contracted rate of payment, and

c. visits for prenatal care and pediatric visits up to the age of two for covered benefits and services provided by a provider who contracts with the preferred provider organization to provide health care benefits and services shall not be subject to a copayment.

2. A copayment which shall be 40% of the scheduled rate of payment established by the participating carrier for covered benefits and services provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services, with the following exceptions:

a. treatment for infertility (including tests) provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's scheduled rate of payment, and

b. outpatient mental health visits provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services shall be subject to a copayment of 50% of the carrier's scheduled rate of payment, and

c. the copayments described in 2., 2.a. and 2.b. above shall be limited to $5,000 in a benefit year for an enrollee or $10,000 in a benefit year for an enrolled sole employee and dependents or guaranteed association member and dependents, and

d. enrollees are responsible for 100% of the charges in excess of the carrier's scheduled rate of payment for health care benefits and services provided by a provider who does not contract with the preferred provider organization to provide health care benefits and services. These amounts are not subject to the limitations in 2.c. on copayment expenses.

3. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital;

4. A copayment which shall be 30% of the contracted rate for prescription drugs provided by a provider who contracts with the preferred provider organization to provide prescription drugs. However this amount shall be 20% when a generic prescription drug is utilized or when a participating carrier has a mandatory generic prescription drug substitution program which has been approved by the program; and a copayment equivalent to that for a 60 day supply of a prescription shall apply to a 90 day supply of the same prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program; and

5. A deductible which shall be $500 per enrollee in a benefit year. The deductible may be reduced by an amount equal to the amount an enrollee with qualifying prior coverage paid toward a deductible under the qualifying prior coverage for services rendered within the 90 days immediately prior to the enrollee's effective date of enrollment in the program. Such reduction may only be applied for the first full or partial benefit year that the enrollee is enrolled in the program.

(3) In the case of participating carriers which offer indemnity plans:

(A) A preferred option shall consist of the following elements:

1. A copayment which shall be 20% of the scheduled rate of payment established by the participating carrier for covered benefits and services, with the following exceptions:

a. treatment for infertility (including tests) shall be subject to a copayment of 50% of the carrier's scheduled rate of payment.

b. outpatient mental health visits shall be subject to a copayment of 50% of the carrier's scheduled rate of payment.

c. enrollees are responsible for 100% of the charges in excess of the carrier's scheduled rate of payment for health care benefits and services. These amounts are not subject to the limitations in Section 2699.6209(a) on copayment expenses.

2. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital;

3. A copayment which shall be 30% of the scheduled rate for prescription drugs. However this amount shall be 20% when a generic prescription drug is utilized; and a copayment equivalent to that for a 60 day supply of a prescription shall apply to a 90 day supply of the same prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program; and

4. A deductible which shall be $250 per enrollee in a benefit year. The deductible may be reduced by an amount equal to the amount an enrollee with qualifying prior coverage paid toward a deductible under the qualifying prior coverage for services rendered within the 90 days immediately prior to the enrollee's effective date of enrollment in the program. Such reduction may only be applied for the first full or partial benefit year that the enrollee is enrolled in the program.

(B) A standard option shall consist of the following elements:

1. A copayment which shall be 20% of the scheduled rate of payment established by the participating carrier for covered benefits and services, with the following exceptions:

a. treatment for infertility (including tests) shall be subject to copayment of 50% of the carrier's scheduled rate of payment, and

b. outpatient mental health visits shall be subject to a copayment of 50% of the carrier's scheduled rate of payment, and

c. enrollees are responsible for 100% of the charges in excess of the carrier's scheduled rate of payment for health care benefits and services. These amounts are not subject to the limitations in Section 2699.6209(a) on copayment expenses.

2. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital;

3. A copayment which shall be 30% of the scheduled rate for prescription drugs. However this amount shall be 20% when a generic prescription drug is utilized; and a copayment equivalent to that for a 60 day supply of a prescription drug shall apply to a 90 day supply of the same prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program; and

4. A deductible which shall be $500 per enrollee in a benefit year. The deductible may be reduced by an amount equal to the amount an enrollee with qualifying prior coverage paid toward a deductible under the qualifying prior coverage for services rendered within the 90 days immediately prior to the enrollee's effective date of enrollment in the program. Such

reduction may only be applied for the first full or partial benefit year that the enrollee is enrolled in the program.

(4) In the case of participating carriers which are health maintenance organizations offering a point of service option or exclusive provider organizations offering a point of service option:

(A) A preferred option shall consist of the following elements:

1. When the enrollee receives covered benefits and services in accordance with the health maintenance organization's or exclusive provider organization's established procedures from providers who contract with the health maintenance organization or exclusive provider organization or when the enrollee, with health plan approval, receives covered benefits and services from providers who do not contract with the health maintenance organization or exclusive provider organization:

a. A $10 copayment per visit for office or home visits, with the following exceptions:

i. treatment for infertility, including tests, shall be subject to a copayment of 50% of the carrier's contracted or scheduled rate of payment,

ii. visits for prenatal care and pediatric visits up to the age of two (2) will be subject to a $5 copayment per visit; and

iii. outpatient mental health visits shall be subject to a $20 per visit copayment;

b. A $15 copayment per outpatient prescription for up to a 31 day supply of a prescription drug. A $15 copayment shall apply to additional supplies of the prescription in up to 31 day increments. However, this amount shall be $10 per prescription for up to 31 days of a prescription drug when a generic prescription drug is utilized or when a participating carrier has a mandatory generic prescription drug substitution program which has been approved by the program. A $10 copayment shall apply to additional supplies of such a prescription in up to 31 day increments.

An exception to the above is that a $30 copayment per prescription shall apply for a 90 day supply of a prescription drug. However, this amount shall be $20 per prescription for a 90 day supply of a generic prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program.

c. A $100 copayment for each hospital or skilled nursing facility admission; and

d. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital.

2. When the enrollee, without health plan approval, receives covered benefits and services from providers who do not contract with the health maintenance organization or exclusive provider organization or when the enrollee receives covered benefits and services in violation of the health plan's established procedures:

a. A copayment which shall be 30% of the scheduled rate of payment established by the participating carrier for covered benefits and services with the following exceptions:

i. the copayments described in 1. above shall be limited to $5,000 in a benefit year for an enrollee or $10,000 in a benefit year for an enrolled sole employee and dependents or guaranteed association members and dependents.

ii. enrollees are responsible for 100% of the charges in excess of the carrier's scheduled rate of payment for health care benefits and services. These amounts are not subject to the limitations in subsection "a" immediately above.

b. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital; and

c. A deductible which shall be $250 per enrollee in a benefit year for an enrolled employee and the employee's enrolled dependents. The deductible may be reduced by an amount equal to the amount an enrollee with qualifying prior coverage paid toward a deductible under the qualifying prior coverage for services rendered within the 90 days immediately prior to the enrollee's effective date of enrollment in the program. Such reductions may only be applied for the first full or partial benefit year that the enrollee is enrolled in the program.

(B) A standard option shall consist of the following elements:

1. When the enrollee receives covered benefits and services in accordance with the health maintenance organization's or exclusive provider organization's established procedures from providers who contract with the health maintenance organization or exclusive provider organization or when the enrollee, with health plan approval, receives covered benefits services from providers who do not contract with the health maintenance organization or exclusive provider organization:

a. A $10 copayment per visit for office or home visits, with the following exceptions:

i. treatment for infertility, including tests, shall be subject to a copayment of 50% of the carrier's contracted or scheduled rate of payment;

ii. visits for prenatal care and pediatric visits up to the age of two (2) will be subject to a $5 copayment per visit; and

iii. outpatient mental health visits shall be subject to a $20 per visit copayment.

b. A $15 copayment per outpatient prescription for up to 31 days of a prescription drug. A $15 copayment shall apply to additional supplies of the prescription in up to 31 day increments. However, this amount shall be $10 per prescription for up to 31 days of a prescription drug when a generic prescription drug is utilized or when a participating carrier has a mandatory generic prescription drug substitution program which has been approved by the program; and a $30 copayment per prescription shall apply for a 90 day supply of a prescription drug. However, this amount shall be $20 per prescription for a 90 day supply of a generic prescription drug. A participating carrier may limit availability of these 90 day supply discounts to prescriptions obtained through a mail order prescription drug program.

c. A $100 copayment for each hospital or skilled nursing facility admission; and

d. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital.

2. When the enrollee, without health plan approval, receives covered benefits and services from providers who do not contract with the health maintenance organization or exclusive provider organization or when the enrollee receives covered benefits and services in violation of the health plan's established procedures:

a. A copayment which shall be 30% of the scheduled rate of payment established by the participating carrier for covered benefits and services with the following exceptions:

i. the copayments described in 1. above shall be limited to $5,000 in a benefit year for an enrollee or $10,000 in a benefit year for an enrolled sole employee and dependents or guaranteed association members and dependents.

ii. enrollees are responsible for 100% of the charges in excess of the carrier's scheduled rate of payment for health care benefits and services. These amounts are not subject to the limitations in subsection "a" immediately above.

b. A $50 copayment whenever use of a hospital emergency room does not result in admission to a hospital; and

c. A deductible which shall be $500 per enrollee in a benefit year for an enrolled employee and the employee's enrolled dependents. The deductible may be reduced by an amount equal to the amount an enrollee with qualifying prior coverage paid toward a deductible under the qualifying prior coverage for services rendered within the 90 days immediately prior to the enrollee's effective date of enrollment in the program. Such reductions may only be applied for the first full or partial benefit year that the enrollee is enrolled in the program.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.633 to section 2699.6209 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 12–29–94 as an emergency; operative 12–29–94 (Register 94, No. 52). A Certificate of Compliance must be transmitted to OAL 4–28–95

or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 12-29-94 order including amendment of subsections (b)(2)(A)2., (b)(2)(B)2., (b)(3)(A)1., and (b)(3)(B)1. transmitted to OAL 4-12-95 and filed 5-22-95 (Register 95, No. 21).
4. Amendment of section heading and section filed 5-2-96; operative 6-1-96 (Register 96, No. 18).
5. Amendment filed 5-8-97; operative 7-1-97 (Register 97, No. 19).

§ 2699.6211. Enrollee Share of Cost for Dental Health Benefit.

(a) Every participating dental health carrier shall require copayments for the dental benefits listed in Subsection 2699.6201(a) of these regulations provided to enrollees subject to the following:

(1) In the case of dental health benefit plans offered by participating carriers which are pre-paid dental organizations:

(A) No copayments are charged for benefits listed under Subsection 2699.6201(a)(1), "Diagnostic and Preventive Benefits", with the following exceptions:

1. Emergency oral exams are subject to a $15 copayment.
2. Palliative treatment is subject to a copayment of $10 per office visit.
3. Specialist consultations are subject to a copayment of $30.
4. Roentgenology is only subject to copayments as follows:
a. Full mouth x-rays — $5 per set.
b. Panoramic films — $5 per set.
5. Dental sealant treatments are subject to a copayment of $5 per tooth.
6. Space maintainers are subject to a $50 copayment.

(B) Copayments for benefits listed under Subsection 2699.6201(a)(2), "Restorative Dentistry", are as follows:

1. Amalgam restorations on primary teeth are subject to a copayment of $14 per tooth including one surface plus $4 per each additional surface.
2. Amalgam restorations on permanent teeth are subject to a copayment of $19 per tooth including one surface plus $4 per each additional surface.
3. Plastic composite, composite resin, or other restorations are subject to a copayment of $22 per tooth including one surface plus $4 per each additional surface. In addition to the copayments, if a precious metal (defined as a metal containing in excess of 50 percent gold or highly noble gold alloy) is used instead of a non-precious metal, charges for the precious metal are the responsibility of the enrollee.
4. Sedative fillings are subject to a copayment of $10.
5. Pin use in conjunction with a restoration is subject to a copayment of $20 per tooth.

(C) Copayments for benefits listed under Subsection 2699.6201(a)(3), "Oral Surgery", are as follows:

1. Extractions (uncomplicated) are subject to a copayment of $15.
2. Extractions solely for orthodontic purposes are subject to a copayment of $20 per tooth.
3. Surgical extractions are subject to a copayment of $30.
4. Removal of impacted teeth is subject to a copayment per tooth as follows:
a. Soft tissue impaction — $35.
b. Partially bony impaction — $50.
c. Completely bony impaction — $75.
5. Biopsy of soft or hard oral tissues is subject to a copayment of $20.
6. Alveolectomies are subject to a copayment of $60 in conjunction with an extraction, and $80 without an extraction.
7. Excision of a cyst or neoplasm in conjunction with an extraction is not subject to a copayment. Excision of cysts and neoplasms as a separate procedure is subject to copayments as follows:
a. Cysts — $25.
b. Neoplasms of no more than 1.25 centimeters — $30.
c. Neoplasms larger than 1.25 centimeters — $60.
8. Removal of palatal torus is subject to a copayment of $50.
9. Removal of mandibular torus is subject to a copayment of $50.
10. Frenulectomy is subject to a copayment of $20.
11. Copayments are not required for incisions and drainage of abscesses.
12. Copayments are not required for post-operative services.

(D) Copayments for benefits listed under Subsection 2699.6201(a)(4), "Endodontics", are as follows:

1. Direct pulp capping is subject to a copayment of $10.
2. Therapeutic pulpotomy is subject to a copayment of $15.
3. Apexification filling with calcium hydroxide is subject to a copayment of $10.
4. Root amputation is subject to a copayment of $60 per root.
5. Root canal therapy is subject to copayments as follows:
a. Bicuspid root canal—$75
b. Molar root canal with one canal—$100.
c. Molar root canal with two canals—$125.
d. Molar root canal with three canals—$150.
e. Molar root canal with four canals—$175.
f. Anterior root canal—$50.
6. An apicoectomy and/or retrograde filling performed in conjunction with root canal therapy is subject to a copayment of $50 per canal. When performed as a separate procedure, an apicoectomy and/or retrograde filling is subject to a copayment of $75 for the first canal and $60 for each additional canal.
7. Vitality tests are not subject to a copayment.

(E) Copayments for benefits listed under Subsection 2699.6201(a)(5), "Periodontics", are as follows:

1. Periodontal scaling performed in the presence of gingival inflammation is subject to a copayment of $15 per quadrant.
2. Periodontal scaling and root planing, gingival flap procedure, and subgingival curettage, are collectively subject to a copayment of $50 per quadrant.
3. Gingivectomy or gingivoplasty is subject to a copayment of the lesser of $100 per quadrant or $35 per tooth.
4. Osseous or muco-gingival surgery is subject to a copayment of the lesser $200 per quadrant or $75 per tooth.
5. Limited occlusal adjustment is subject to a copayment of $20.

(F) Copayments for benefits listed under Subsection 2699.6201(a)(6), "Crown and Fixed Bridges", are as follows:

1. Stainless steel crowns (prefabricated) are subject to a copayment of $25.
2. Laboratory processed composite resin crowns, inlays or onlays are subject to a copayment of $180.
3. Porcelain or ceramic crowns, porcelain fused to metal crowns, full and 3/4 cast metal crowns, and metallic, porcelain, or ceramic inlays or onlays, are subject to a copayment of $200.
4. Prefabricated post and core for crowns or bridges, including canal preparation, build up material, and any pins, is subject to a copayment of $50.
5. Cast or laboratory post and core for crowns or bridges, including canal preparations, build up material, and any pins, is subject to a copayment of $75.
6. Recementation of crowns, inlays or onlays is subject to a copayment of $10.
7. Repair of a crown is subject to a copayment of $25.
8. Bridge pontics and bridge abutments made of metal, porcelain or ceramic, porcelain fused to metal, and full cast metal are subject to a copayment of $200 for each unit.
9. Recementation of bridges is subject to a copayment of $10 per abutment.
10. Repair of abutments or pontics is subject to a copayment of $25 per unit.
11. Repair or replacement of pontic veneer is subject to a copayment of $40.

(G) Copayments for benefits listed under Subsection 2699.6201(a)(7), "Removable Prosthetics", are as follows:

1. Dentures are subject to copayments as follows:

a. Partial upper or lower without clasps—$50.

b. Partial upper or lower with metal lingual or palatal bar, clasps and acrylic saddles, and acrylic base or cast metal framework—$250.

c. Full upper or lower dentures, standard procedure—$230.

d. Full upper or lower dentures, immediate procedure—$250.

2. Reline or rebase for an upper, lower or partial denture is subject to a copayment per unit as follows:

a. Office—$30.

b. Laboratory—$60.

3. Repair of, or addition to, complete upper or lower, or partial dentures is subject to a copayment per unit as follows:

a. Repair of broken unit—$25

b. Replacement of a tooth or addition of a tooth—$25.

4. Tissue conditioning for complete upper or lower, or for partial dentures is subject to a copayment per unit of $25.

5. Copayments are not required for denture adjustments.

(H) Copayments for benefits listed under Subsection 2699.6201(a)(8), "Orthodontia", are as follows:

1. Treatment for the initial 24 months of an orthodontic treatment program is subject to a $350 start-up fee per patient, and is also subject to a copayment of $1,150 for enrollees up to age 18, and a copayment of $1,500 for enrollees 18 years of age and older.

2. Treatment beyond the initial 24 months is subject to an additional copayment of $50 per month, until active treatment is concluded.

3. The retention phase of an orthodontic treatment program shall be subject to a copayment of up to $350.

4. Alternative, partial or interceptive orthodontic treatment is subject to a copayment of 50% of usual, customary or reasonable charges.

(I) There are no copayments for benefits listed under Subsection 2699.6201(a)(9), "Other Dental Benefits."

(J) Other charges shall apply as follows:

1. Failure to cancel an appointment 24 hours in advance of the appointment may incur a charge of up to $20.

(K) Enrollees are responsible for 100% of any additional charges for services provided in excess of the benefit level.

(2) In the case of dental benefit plans offered by participating dental carriers which are fee-for-service dental organizations:

(A) Exclusive of orthodontia, the sum of the benefits provided in a benefit year shall not exceed $1,000 for a person enrolled in the dental benefits plan.

(B) The sum of lifetime benefits provided for orthodontia shall not exceed $1,500 for a person enrolled in the dental benefits plan.

(C) An annual benefit year deductible per enrollee shall apply. The deductible per enrollee shall be $50, with a family maximum of $150. No deductible shall apply for services for which no copayment is required.

(D) Copayments are listed as a percentage of the covered benefit, which is limited to usual, customary or reasonable charges.

(E) No copayments are charged for benefits listed under Subsection 2699.6201(a)(1), "Diagnostic and Preventive Benefits", with the following exceptions:

1. Emergency oral examinations are subject to a 20% copayment per occurrence.

2. Palliative treatments are subject to a copayment of 20%.

3. Specialist consultations are subject to a copayment of 20%.

4. Roentgenology is only subject to copayments for full mouth x-rays and panoramic films, which are each subject to a copayment of 20%.

5. Dental sealant treatments are subject to a copayment of 20% per tooth.

6. Space maintainers are subject to a 50% copayment.

(F) Copayments for benefits listed under Subsection 2699.6201(a)(2), "Restorative Dentistry", are 20%. In addition to the copayments, if a precious metal (defined as a metal containing in excess of 50 percent gold *or highly noble gold alloy) is used instead* of a non-precious metal, charges for the precious metal are the responsibility of the enrollee.

(G) Copayments for benefits listed under Subsection 2699.6201(a)(3), "Oral Surgery", are 20%, with the following exceptions:

1. Extractions solely for orthodontic purposes are subject to a copayment of 50%.

2. Excisions of cysts or neoplasms in conjunction with an extraction are not subject to a copayment.

3. Incisions and drainage of abscesses are not subject to a copayment.

4. Post-operative services are not subject to a copayment.

(H) Copayments for benefits listed under Subsection 2699.6201(a)(4), "Endodontics", are 20%, with the following exceptions:

1. Root amputations are subject to a copayment of 50%.

2. Apicoectomy and/or retrograde fillings are subject to a copayment of 50%.

3. Vitality tests are not subject to a copayment.

(I) Copayments for benefits listed under Subsection 2699.6201(a)(5), "Periodontics", shall be 20%, with the following exceptions:

1. Gingivectomy or gingivoplasty is subject to a copayment of 50%.

2. Osseous or muco-gingival surgery is subject to a copayment of 50%.

(J) Copayments for benefits listed under Subsection 2699.6201(a)(6), "Crowns and Fixed Bridges", shall be 50%.

(K) Copayments for benefits listed under Subsection 2699.6201(a)(7), "Removable Prosthetics", shall be 50% with the following exception:

1. Copayments are not required for denture adjustments.

(L) Copayments for benefits listed under Subsection 2699.6201(a)(8), "Orthodontia", shall be subject to a copayment of 50%.

(M) There are no copayments for benefits listed under Subsection 2699.6201(a)(9), "Other Dental Benefits."

(N) Other charges shall apply as follows:

1. Failure to cancel an appointment 24 hours in advance of the appointment may incur a charge of up to $20.

(O) Enrollees are responsible for 100% of any additional charges for services provided in excess of the benefit level.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5-23-94 as an emergency; operative 5-23-94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9-20-94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5-23-94 order transmitted with amendment of subsection (a)(2)(G)4 to OAL 9-16-94 and filed 10-27-94 (Register 94, No. 43).
3. Editorial correction of subsection (a)(1)(F)11 (Register 94, No. 43).
4. Amendment of subsection (a)(1)(A) filed 10-18-95; operative 10-18-95 pursuant to Government Code section 11343.4(d) (Register 95, No. 42).

§ 2699.6213. Pre-Existing Condition Exclusions.

(a) Participating carriers who are health maintenance organizations, exclusive provider organizations, health maintenance organizations offering a point of service option or exclusive provider organization's offering a point of service option may not subject enrollees to a pre-existing condition exclusion period.

(b) Participating carriers who are preferred provider organizations or who offer an indemnity plan in the program may subject enrollees to a pre-existing condition exclusion period. During the pre-existing condition exclusion period, no benefits or services related to a pre-existing condition shall be covered.

(c) The pre-existing condition exclusion period shall be six (6) months following the individual's effective date of coverage.

(d) In determining whether a preexisting condition provision applies to any person, a participating carrier shall credit the time the person was covered under qualifying prior coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 30 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage with the succeeding plan contract within the applicable

enrollment period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under qualifying prior coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within one hundred eighty (180) calendar days, exclusive of any waiting period, and applies for coverage under the succeeding health benefit plan within the applicable period.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. Renumbering of former section 2699.634 to section 2699.6213 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. New subsection (a) and subsection relettering filed 5–2–96; operative 6–1–96 (Register 96, No. 18).
3. Amendment of subsection (d) filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6215. Waiting Periods for Specific Dental Benefits.

Enrollees of the dental benefits plans provided through the Program who have not had qualifying prior dental coverage for the 6 consecutive months prior to enrollment in the program shall be subject to a waiting period of 6 months, for benefits listed under Sub–sections 2699.6201(a)(6) and (7). A waiting period of 12 months shall apply to all enrollees for benefits listed under Subsection 2699.6201(a)(8). However, participating dental plans shall credit time enrolled in dental benefits through the program with other participating dental plans toward this waiting period.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10741, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
3. Amendment filed 4–25–96; operative 5–25–96 (Register 96, No. 17).

§ 2699.6217. Benefit Appeals.

When a small employer, employee, or dependent is dissatisfied with any action, or inaction, of the program's participating carrier or participating dental carrier with which he or she is enrolled, the person shall resolve the dispute with the participating carrier or participating carrier according to its established policies and procedures.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10733, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.635 to section 2699.6217 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6241. Waiting Period for Sole Employees.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6241 to section 2699.6135 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6241.5. Waiting Period for Guaranteed Association Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6241.5 to section 2699.6137 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6242. Open Enrollment Period for Sole Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6242 to section 2699.6139 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6242.5. Open Enrollment Period for Guaranteed Association Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6242.5 to section 2699.6141 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6243. Other Enrollment Additions for Sole Employees and Dependents.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order, including amendment of subsections (a)(3) and (b)(2), transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6243 to section 2699.6145 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6243.5. Other Enrollment Additions for Member Employers.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6243.5 to section 2699.6147 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6243.6. Other Enrollment Additions for Individual Members.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6243.6 to section 2699.6149 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6244. Enrollment.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10733, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6244 to section 2699.6153 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6261. Disenrollment of Sole Employees.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Amendment of section heading and text filed 12–30–94 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6261 to section 2699.6177 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6261.5. Disenrollment of Member Employees and Dependents.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6261.5 to section 2699.6181 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6262.5. Disenrollment of Individual Members and Dependents.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10743, Insurance Code.

HISTORY

1. New section filed 12–30–93 as an emergency; operative 12–30–93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4–28–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12–30–93 order including renumbering and amending former section 2699.6262.5 to section 2699.6183 transmitted to OAL 4–25–94 and filed 5–27–94 (Register 94, No. 21).

§ 2699.6271. COBRA Benefits.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5–5–93 as an emergency; operative 7–1–93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10–29–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–5–93 order transmitted to OAL 8–27–93 and filed 10–12–93 (Register 93, No. 42).
3. Renumbering of former section 2699.6271 to section 2699.6191 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

Article 4. Employer Premiums

§ 2699.6300. Risk Categories.

Health benefits plan rates shall be based exclusively on the following risk categories:

(a) Geographic region of sole employee's or guaranteed association member's residence.

(1) The six geographic regions for sole employee's or guaranteed association members residing within the State of California shall be as follows:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The eight geographic regions for sole employees or member employees residing in areas of the United States except the State of California shall be as follows:

(A) Area A shall consist of the States of Maine, New Hampshire, Vermont, the State of New York except Bronx, Kings, Manhattan, Nassau, Queens, Richmond, Rockland, Westchester and Suffolk Counties and the Territory of Guam.

(B) Area B shall consist of the States of Arkansas, Iowa, Kentucky, Montana, North Carolina, Oregon, South Carolina, and the Commonwealth of Puerto Rico.

(C) Area C shall consist of the States of Delaware, Hawaii, Idaho, Mississippi, Nebraska, North Dakota, Ohio, South Dakota, Tennessee, Washington, West Virginia, Wisconsin, and the State of Illinois except the counties of Cook, Dupage, Kane, Lake and McHenry.

(D) Area D shall consist of the States of Colorado, Georgia, Indiana, Kansas, Maryland, Massachusetts, Michigan, Missouri, Oklahoma, Pennsylvania, Rhode Island, Utah, Wyoming, and the State of Florida except Dade and Broward counties.

(E) Area E shall consist of the States of Alabama, Connecticut, Minnesota, New Jersey, New Mexico, Virginia, and counties of Cook, Dupage, Kane, Lake, and McHenry in the State of Illinois.

(F) Area F shall consist of the States of Alaska, Arizona, Louisiana, and the District of Columbia, and the State of Texas except Galveston and Harris counties.

(G) Area G shall consist of the State of Nevada and the counties of Bronx, Kings, Manhattan, Nassau, Queens, Richmond, Rockland, Westchester and Suffolk in the State of New York, and the counties of Galveston and Harris in the State of Texas.

(H) Area H shall consist of the counties of Dade and Broward in the State of Florida.

(b) Age of enrolled sole employee or guaranteed association member. The seven (7) age groups shall be as follows:

(1) Under 30;

(2) 30–39 years of age;
(3) 40–49 years of age;
(4) 50–54 years of age;
(5) 55–59 years of age;
(6) 60–64 years of age; and
(7) 65 years of age and over.

(c) Family size category of enrolled sole employee or guaranteed association member. The four (4) family size categories shall be as follows:

(1) Sole employee or guaranteed association member only.

(2) Sole employee or guaranteed association member and spouse.

(3) Sole employee and dependent child or dependent children, or guaranteed association member and dependent child or dependent children.

(4) Sole employee and spouse, and dependent child or dependent children, or guaranteed association member and spouse and dependent child or dependent children.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10746, Insurance Code.

HISTORY

1. Relocation of article heading and renumbering and amendment of former section 2699.640 to section 2699.6300 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6301. Risk Categories for Dental benefits.

Dental benefits plan rates shall be based exclusively on the following risk categories:

(a) Geographic region of sole employee's or guaranteed association member's residence within the state of California. The six geographic regions shall be as specified in Subsection 2699.6300(a)(1).

(b) Family size category of enrolled sole employee or guaranteed association member. The four (4) family size categories shall be as specified in Subsection 2699.6300(c).

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10746, Insurance Code.

HISTORY

1. New section filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6303. Annual Health Benefit Plan Rates.

Health benefit plan rates and dental benefit plan rates shall be established for each rating period and the rating period for the program shall be a twelve (12) month period.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.641 to section 2699.6303 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6305. Change of Risk Category.

(a) When an enrolled sole employee, member employee, or individual member changes age groups as specified in Section 2699.6300(b) the rate change shall go into effect at the beginning of the next rating period.

(b) When an enrolled sole employee, member employee, or individual member changes geographic region of residence as specified in Section 2699.6300(a) but is not transferring from one participating carrier or participating dental carrier to another, or changes family size category as specified in Section 2699.6300(c), the change in the employer premium or individual member premium shall be calculated for and included in the next employer premium or individual member premium following the change.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.642 to section 2699.6305 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 5–23–94 order transmitted with amendment of subsection (b) to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).

§ 2699.6307. Program Participation Fee.

(a) This subsection applies to sole employers and guaranteed associations with effective dates of coverage prior to September 1, 1998 who have not made an election pursuant to Section 2699.6116.

(1) The program shall establish a program participation fee to be paid as part of the employer premium or individual member premium. The program shall include an amount to be paid for participation for dental coverage if the employer or individual member participates in the dental benefits option. The amount of the fee shall be sufficient to cover necessary administrative costs in connection with the program. Small employers enrolling after July 1, 1996 and before July 1, 1997 who do not utilize the services of an agent or broker shall pay, as an additional part of their program participation fee, a monthly amount equal to the monthly amounts specified in subsections 2699.6194(a)(4) and 2699.6196(a)(1)(D) for the first year and subsections 2699.6194(a)(5)(B) and 2699.6196(a)(1)(E)2. for the second year to compensate for the program's application, open enrollment and requalification assistance. Small employers enrolling on or after July 1, 1997 who do not utilize the services of an agent or a broker shall pay, as an additional part of their program participation fee, a monthly amount equal to the monthly amount specified in subsections 2699.6194(a)(4) and 2699.6196(a)(1)(D) for the first year and subsections 2699.6194(a)(5)(C) and 2699.6195(a)(1)(E)3. for the second year to compensate for these services.

(b) This section applies to sole employers and guaranteed associations with effective dates of coverage on or after September 1, 1998 or who have made an election pursuant to Section 2699.6116.

(1) The program shall establish a program participation fee that is a percentage of the comprehensive individual medical premium and the comprehensive individual dental premium.

(2) For sole employers and member employers the program participation fee shall be an amount equal to three and one half percent of the comprehensive individual medical premium and the comprehensive individual dental premium.

(3) For individual members the program participation fee shall be an amount equal to ten percent of the comprehensive individual medical premium and the comprehensive individual dental premium.

(4) The program participation fee shall also include all amounts so designated pursuant to Sections 2699.6194(b), 2699.6195(b), 2699.6196(b) and 2699.6197(b).

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.643 to new section 2699.6307 filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be transmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5–23–94 order transmitted to OAL 9–16–94 and filed 10–27–94 (Register 94, No. 43).
3. Editorial correction of HISTORY 1 (Register 94, No. 43).
4. Amendment filed 4–25–96; operative 5–25–96 (Register 96, No. 17).
5. Amendment filed 6–3–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 23).
6. Amendment filed 7–3–98 as an emergency; operative 7–3–98 (Register 98, No. 27). A Certificate of Compliance must be transmitted to OAL by 11–2–98 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 7–3–98 order, including amendment of subsection (a)(1), transmitted to OAL 10–2–98 and filed 11–16–98 (Register 98, No. 47).

§ 2699.6309. Notification of Rate Changes.

The program shall notify guaranteed associations, participating employers and participating individual members of plan rates no later than thirty (30) calendar days prior to the start of the rating period for which the rates are in effect.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.644 to section 2699.6309 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).
2. Amendment filed 5–23–94 as an emergency; operative 5–23–94 (Register 94, No. 21). A Certificate of Compliance must be tranmitted to OAL by 9–20–94 or emergency language will be repealed by operation of law on the following day.

§ 2699.6311. Premium Payment to Program.

Premium payment procedures for sole employers and for member employers and for individual members which submit premiums directly to the program shall be as follows:

(a) Participating employers and participating individual members shall submit their employer premium or individual member premium to the program each month so that it is received no later than the due date set by the program.

(b) Each month the program shall notify participating employers or participating individual members of the employer premium or individual member premium due to the program, the due date of the employer premium or individual member premium, and the enrollees for whom payment is included in the employer premium or individual member premium. This notification shall be made at least fifteen (15) calendar days in advance of the employer premium due date.

(c) The participating employer's or participating individual member's obligation to submit the employer premium or individual member premium required by paragraph (a) above is not contingent upon receipt of the notice specified in paragraph (b) above. If the participating employer or participating individual member does not receive the notice specified in paragraph (b) above, the participating employer or participating individual member shall made a good faith effort to determine the amount of the employer premium or individual member premium and shall submit a payment of that amount.

(d) The due date for employer premiums and individual premiums is the first day covered by the premium.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10742, Insurance Code.

HISTORY

1. Renumbering of former section 2699.645 to section 2699.6311 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6313. Overdue Payments; Late Fees; Disqualification for Participating Employers.

(a) Participating employers whose employer premiums are not paid in full by the due date shall be considered to be overdue. No act or failure to act on the part of a guaranteed association that is collecting premiums for the guaranteed association's members shall encumber the program from proceeding as herein set forth.

(b) The program shall notify participating employers of the overdue premium payment and the potential of disqualification from the program within fifteen (15) calendar days following the due date.

(c) Overdue employer premiums shall be subject to a late fee equal to 5% of the employer premium.

(d) Employer premiums more than thirty–one (31) calendar days overdue shall result in the participating employer being disqualified pursuant to Section 2699.6167(a)(2) or Section 2699.6173(a)(3). The final date of coverage for participating employers who are disqualified pursuant to Section 2699.6167(a)(2) or Section 2699.6173(a)(3) shall be retroactive to the last day for which the employer premium was paid in full.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.646 to section 2699.6313 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6315. Overdue Payments; Late Fees; Disqualification for Individual Members.

(a) A participating individual member whose individual member premium is not paid in full by the due date shall be considered to be overdue. No act or failure to act on the part of a guaranteed association that is collecting premium for the guaranteed association's members shall encumber the program from proceeding as herein set forth.

(b) The program shall notify participating individual members of the overdue premium payment and the potential of disqualification from the program within fifteen (15) calendar days following the due date.

(c) Overdue employer premiums or individual member premiums shall be subject to a late fee equal to 5% of the employer or individual member premium.

(d) Individual member premiums more than thirty–one (31) calendar days overdue shall result in the member employer or individual member being disqualified pursuant to Section 2699.6175. The final date of coverage for member employers or individual members who are disqualified pursuant to Section 2699.6173 or 2699.6175 shall be retroactive to the last day for which individual member premium was paid in full.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.646.5 to section 2699.6315 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6317. Program Reinstatement Fee.

The program reinstatement fee shall be equal to 10% of the employer premium or individual premium.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6461 to section 2699.6317 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6319. Reinstatement Following Disqualification for Non–Payment of Premium.

(a) Unless precluded by subsection (c) below, participating employers and individual members disqualified for nonpayment of their monthly premium may reinstate in the program if the participating employer or individual member remits the employer or individual member premium, the late fee, the program reinstatement fee, and the subsequent month's employer or individual member premium and any applicable late fee to the program no later than fifteen (15) calendar days following the issuance of the notice of disenrollment for nonpayment of premium. Payment to the program shall be made either directly or through a qualified guaranteed association according to normal premium payment practice.

(b) If an amount is received pursuant to (a) above later than fifteen (15) calendar days following the issuance of the notice, of disenrollment for nonpayment, then the program shall return the amount within 20 calendar days of receiving it.

(c) A participating employer or individual member shall not be reinstated more than twice in a twelve month period of time.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6462 to section 2699.6319 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6321. Participating Employer Payment Requirement.

(a) A participating employer shall pay the employer premium unless the employer requests disqualification pursuant to Section 2699.6167(a)(3).

(b) A participating employer shall pay each individual premium until the effective date of disenrollment.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6463 to section 2699.6321 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

§ 2699.6323. Individual Member Payment Requirement.

An individual member shall pay the individual member premium due for the individual member and dependents, if any, until the effective date of disenrollment.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. Renumbering and amendment of former section 2699.6463.5 to section 2699.6323 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

Article 5. Appeals

§ 2699.6400. Appeals to the Board.

Certain program decisions may be appealed to the Board. If a guaranteed association, member employer, member employee, individual member, sole employer, or sole employee believes that a written decision on one of the following specified issues was made in violation of the program statutes or regulations, or other written representation of program policy made to the entity or individual by the program or the Board, that entity or individual may file an appeal with the Board.

Decisions that may be appealed are:

1. A decision that an association or employer is not qualified to participate or continue to participate in the program.

2. A decision that an association member or employee, or dependent of either, is not eligible for enrollment or continuing enrollment in the program.

3. A decision as to the effective date of health plan coverage.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. Relocation of article heading and renumbering and amendment of former section 2699.650 to section 2699.6400 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

2. Repealer and new section filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6401. Filing an Appeal.

(a) An appeal shall be filed in writing with the Executive Director within sixty (60) calendar days of the date of the notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed;

(2) A statement specifically describing the issues which are disputed by the appellant;

(3) A statement specifically describing the program statute or regulation, or other written representation of program policy, that the appellant believes the program violated.

(4) A statement of the resolution requested by the appellant; and

(5) Any other relevant information the appellant wants to include.

(c) Any appeal that does not specifically allege a violation of a program statute or regulation, or other written representation of program policy, will be deemed to be a request for program review pursuant to Section 2699.6404.

(d) Any appeal that does specifically allege a violation of program statutes or regulation or other written representation of program policy, but fails to include any other necessary information shall be returned to the appellant without review. The appellant may resubmit the appeal. The resubmittal shall be filed within the time limits of subsection (a) or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. Renumbering of former section 2699.651 to section 2699.6401 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

2. Amendment filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6403. Administrative Review.

(a) Any appellant who files an appeal pursuant to Section 2699.6400 shall receive an initial administrative review of the appeal.

(b) Administrative reviews of appeals shall be conducted in two steps. Each appeal will be reviewed by the program to determine if the requested resolution is required by the statutes and regulations governing the program, or required in order to be consistent with a written representation of program policy made by the program or the Board. If so, the appropriate action will be taken and the appellant will be notified. If not, the appellant will be so notified and informed that they may request review by the Executive Director. Such a request must be filed in writing with the Executive Director within 30 days of the date of the notice of the program determination, and shall include the information specified in Subsection 2699.6401(b).

(c) In conducting an administrative review of an appeal, the Executive Director may contact the appellant and/or the participating health plan for further information.

(d) The Executive Director's decision shall be in writing.

(e) The appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the Executive Director. Such a request shall be filed within thirty (30) calendar days of receipt of the Executive Director's decision. It shall include a clear and concise statement of what action is being appealed, and the reason(s) the Executive Director's decision is not correct.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. Renumbering of former section 2699.652 to section 2699.6403 filed 5–27–94; operative 5–27–94 (Register 94, No. 21).

2. Amendment of subsection (e) filed 1–10–95 as an emergency; operative 1–10–95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5–10–95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 1–10–95 order transmitted to OAL 4–25–95 and filed 6–7–95 (Register 95, No. 23).

4. Amendment of subsections (a) and (b) and amendment of NOTE filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6404. Program Review.

In addition to the appeal process established above, the Board has established a program review process. If a guaranteed association, member employer, member employee, individual member, sole employer, or sole employee is not eligible to file an appeal pursuant to Section 2699.6400, but wants to have any program decision reviewed, the person or entity may request that the program review the decision. A review pursuant to this section is separate from and independent of an appeal pursuant to Section 2699.6400 and a person or entity that files a request pursuant to this section shall not thereby gain any right of appeal. Pursuant to Section 2699.6217, any dissatisfaction with an action of a participating carrier or participating dental carrier shall be resolved with the carrier rather than by requesting program review.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. New section filed 5–5–97; operative 7–1–97 (Register 97, No. 19).

§ 2699.6405. Hearings.

When an appeal which requests an administrative hearing is received, the appeal shall be set for hearing as follows:

(a) Administrative hearings of appeals will be conducted according to the appeal procedures, including pre– and post–hearing procedures, set forth in Chapter 2.5 (commencing with section 251) of Division 2 of Title 1 of the California Code of Regulations. Chapter 2.5 is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private non-profit human service organization shall be deemed reference to the petitioner.

(3) Reference to the grievance procedure established in accordance with Health and Safety Code section 38036 shall be deemed reference to the administrative review process set forth in section 2699.6403.

(4) Reference to Health and Safety Code sections providing the bases, grounds, authorization or procedures for appeals shall be deemed reference to the bases and authorization for appeal found in section 2699.6400, and the appeal procedures found in this section.

(5) The 30-day time period specified in section 251(b) shall be extended to 60 days, and the 10-day time period in section 252(a) shall be extended to 30 days.

(6) If the proposed decision submitted to the Board is not adopted as the decision, the Board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(7) The decision of the Board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

(b) The Board may elect to have a hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. Renumbering of former section 2699.653 to section 2699.6405 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).
2. Amendment of subsection (a) and new subsections (a)(1)-(a)(7) filed 1-10-95 as an emergency; operative 1-10-95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5-10-95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 1-10-95 order including amendment of subsection (a) transmitted to OAL 4-25-95 and filed 6-7-95 (Register 95, No. 23).

§ 2699.6407. Conduct of Hearing by Hearing Officer.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. Renumbering of former section 2699.654 to section 2699.6407 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).
2. Repealer filed 1-10-95 as an emergency; operative 1-10-95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5-10-95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 1-10-95 order transmitted to OAL 4-25-95 and filed 6-7-95 (Register 95, No. 23).

§ 2699.6409. Decision by Appeal Hearing by Hearing Officer.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Sections 10731 and 10748, Insurance Code.

HISTORY

1. Renumbering of former section 2699.655 to section 2699.6409 filed 5-27-94; operative 5-27-94 (Register 94, No. 21).
2. Repealer filed 1-10-95 as an emergency; operative 1-10-95 (Register 95, No. 2). A Certificate of Compliance must be transmitted to OAL 5-10-95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 1-10-95 order transmitted to OAL 4-25-95 and filed 6-7-95 (Register 95, No. 23).

§ 2699.6461. Program Reinstatement Fee.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5-5-93 as an emergency; operative 7-1-93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10-29-93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5-5-93 order transmitted to OAL 8-27-93 and filed 10-12-93 (Register 93, No. 42).
3. Amendment filed 12-30-93 as an emergency; operative 12-30-93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4-28-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12-30-93 order including renumbering former section 2699.6461 to section 2699.6317 transmitted to OAL 4-25-94 and filed 5-27-94 (Register 94, No. 21).

§ 2699.6462. Reinstatement Following Disqualification for Non-Payment of Premium.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5-5-93 as an emergency; operative 7-1-93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10-29-93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5-5-93 order transmitted to OAL 8-27-93 and filed 10-12-93 (Register 93, No. 42).
3. Amendment filed 12-30-93 as an emergency; operative 12-30-93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4-28-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12-30-93 order including renumbering and amending former section 2699.6462 to section 2699.6319 transmitted to OAL 4-25-94 and filed 5-27-94 (Register 94, No. 21).

§ 2699.6463. Participating Employer Payment Requirement.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 5-5-93 as an emergency; operative 7-1-93 (Register 93, No. 19). A Certificate of Compliance must be transmitted to OAL 10-29-93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 5-5-93 order transmitted to OAL 8-27-93 and filed 10-12-93 (Register 93, No. 42).
4. Certificate of Compliance as to 12-30-93 order including renumbering and amending former section 2699.650 to section 2699.6400 transmitted to OAL 4-25-94 and filed 5-27-94 (Register 94, No. 21).
3. Amendment of section heading and subsection (b) filed 12-30-93 as an emergency; operative 12-30-93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4-28-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12-30-93 order including renumbering and amending former section 2699.6463 to section 2699.6321 transmitted to OAL 4-25-94 and filed 5-27-94 (Register 94, No. 21).

§ 2699.6463.5. Individual Member Payment Requirement.

NOTE: Authority cited: Section 10731, Insurance Code. Reference: Section 10731, Insurance Code.

HISTORY

1. New section filed 12-30-93 as an emergency; operative 12-30-93 (Register 93, No. 53). A Certificate of Compliance must be transmitted to OAL by 4-28-94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 12-30-93 order including renumbering former section 2699.6463.5 to section 2699.6323 transmitted to OAL 4-25-94 and filed 5-27-94 (Register 94, No. 21).

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Title 10. Investment

Chapter 5.8. Managed Risk Medical Insurance Board Healthy Families Program

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Chapter 5.8. Managed Risk Medical Insurance Board Healthy Families Program

Article 1. Definitions

§ 2699.6500. Definitions.

(a) "Access for Infants and Mothers (AIM) Program" means the State funded program operated pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the California Insurance Code, and that provides low–cost health care coverage for pregnant women and the newborns of subscribers who are enrolled in the AIM program prior to July 1, 2004.

(b) "Agriculture" means farming in all its branches and includes; the cultivation and tillage of the soil, the production of dairy products, the production, cultivation growing, and harvesting of any agricultural or horticultural commodities, the raising of livestock, bees, forbearing animals, or poultry, any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market.

(c) "AIM infant" means a child born to an AIM subscriber who is enrolled in the AIM program on or after July 1, 2004.

(d) "Alaskan Native" means any person who is an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601.

(e) "American Indian" means any person who is eligible under federal law (25 U.S.C. Section 1603) to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.

(f) "Anniversary date" means the day each year that corresponds to the day and month a person's coverage began in the program.

(g) "Applicant" means:

(1) A person age 18 or over who is a parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.

(2) A person who is applying for coverage on his or her own behalf and who is 18 years of age; or an emancipated minor; or a minor not living in the home of a parent, a legal guardian, caretaker relative, foster parent, or stepparent.

(3) A minor who is applying for coverage on behalf of his or her child.

(4) A person who is age 19 or over and who is applying for coverage on his or her own behalf and/or that of another child–linked adult.

(h) "Benefit year" means the twelve (12) month period commencing July 1 of each year at 12:01 a.m.

(i) "Board" means the Managed Risk Medical Insurance Board.

(j) "Caretaker relative" means a relative who provides care and supervision to a child if there is no parent living in the home. The caretaker relative may be any relation by blood, marriage, or adoption.

(k) "Child–linked adult" means:

(1) A parent living in the home with his or her child under age 19 who is enrolled in the program, or in no–cost Medi–Cal, or is eligible and applying for no–cost Medi–Cal.

(2) A stepparent living in the home with the parent described in (1).

(3) A caretaker relative living in the home with a child under age 19 who is enrolled in the program, or in no–cost Medi–Cal, or is eligible and applying for no–cost Medi–Cal. For any child or group of siblings, only one (1) caretaker relative may be eligible as a child–linked adult.

(4) A legal guardian living in the home with a child under age 19 who is enrolled in the program, or in no–cost Medi–Cal, or is eligible and applying for no–cost Medi–Cal. For any child or group of siblings, only one (1) legal guardian may be eligible as a child–linked adult.

(*l*) "Community provider plan" means that participating health plan in each county that has been so designated by the Board pursuant to Section 2699.6805.

(m) "Family contributions" means the monthly cost to an applicant for "family child contributions" and "family parent contributions." Family contributions do not include copayments for services.

(n) "Family child contributions" means the monthly cost to an applicant to enable a subscriber child or subscriber children to participate in the program. Family child contributions do not include copayments for services.

(o) "Family parent contributions" means the monthly cost to an applicant to enable a subscriber parent or subscriber parents to participate in the program. Family parent contributions do not include copayments for services.

(p) "Family contribution sponsor" means a person or entity that is registered with the Program and that pays the family child contributions and/or family parent contributions on behalf of an applicant for any twelve (12) consecutive months of the subscriber child or subscriber parent's participation in the program. A family contribution sponsor may sponsor a subscriber parent linked to a subscriber child enrolled in the program if the subscriber child is sponsored, or may sponsor only the subscriber parent if the subscriber parent is not linked to any subscriber children enrolled in the program and instead is linked to a child enrolled in no–cost Medi–Cal.

(q) "Family member" means the following persons living in the home, unless the individual receives public assistance benefits such as SSI/SSP:

(1) Children under age 21 of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.

(3) The stepparents of the child or sibling children.

(4) An unborn child of any family member.

(5) Children under age 21 who are away at school and who are claimed as tax dependents.

(r) "Family value package" means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by summing the second lowest price health plan, the second lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service area which does not include zip codes in which at least eighty–five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package. In all family value package calculations, the health plan rate to be used is the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. When the Board calculates the family value package, it shall base the calculation on the plan prices expected to be available for the anticipated health, dental and vision plan contract terms. Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such in-

creased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent (50%) of subscribers or one–thousand (1,000) subscribers in a county to change their dental plan.

(s) "Federal Poverty Level" means the level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(t) "Household income" means the total annual income of all family members in a household. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, self–employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

(u) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member working or receiving disability worker's compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and dependent care expenses of up to $175 for a disabled dependent.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) A maximum of $50 for child support payments or alimony received. If less than $50 in child support and/or alimony is received, the deduction can only be for the amount received.

(v) "Indian Health Service Facility" means a tribal or urban Indian organization operating health care programs or facilities with funds from the United States Department of Health and Human Service's Indian Health Service, pursuant to the Indian Health Care Improvement Act (25 U.S.C. Section 1601) or the Snyder Act (25 U.S.C. Section 13).

(w) "Living in the home" means all of the following:

(1) Physically present in the home;

(2) Temporarily absent from the home because of hospitalization, visiting, vacation, work–related trips, or other similar reasons. A temporary absence is normally one where a person leaves and returns to the home in the same or the following month.

(3) Away at school or vocational training if the person will resume living in the home as evidenced by the person's return to the home for vacations, weekends, and other times.

(4) When a child stays alternately with each of his or her parents and the child's parents are separated or divorced, the home in which the child is living shall be determined as follows:

(A) The child is determined to be living in the home of the parent with whom the child stays for the majority of the time.

(B) If the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who has the majority of the responsibility for the care of the child. Factors that determine majority responsibility include but are not limited to which parent decides where the child attends school, deals with the school on educational decisions and problems, controls participation in extracurricular and recreational activities, arranges medical and dental care services, claims the child as a tax dependent, and purchases and maintains the child's clothing.

(C) If both parents exercise an equal share of responsibility for the child and the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who meets one of the following conditions in the order specified:

1. Is designated, through mutual agreement of both parents, as the primary parent for purposes of the program or Medi–Cal.

2. Is otherwise eligible for the program.

3. If both parents are eligible for the program then the child is determined to be living in the home of the parent who first applied for the program or Medi–Cal on behalf of the child.

(x) "Migratory worker" means an individual whose principal employment is in agriculture, fishing, and/or forestry, on a seasonal basis, as opposed to year–round employment; and who, for purposes of employment, does establish a temporary place of residence. Migrant workers live in a work area temporarily. Such employment must have been within the last twenty–four months.

(y) "Parent" means the natural or adoptive parent of a child.

(z) "Parental coverage start date" means the effective date for which the State of California enacts appropriation for the coverage of child linked adults pursuant to a budget act and/or any other applicable state statute.

(aa) "Participating dental plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the Board to provide coverage to program subscribers:

(1) A dental insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(bb) "Participating health plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code. The term health care service plan shall include a plan operating as a geographic managed care plan as defined in Insurance Code Section 12693.16, in the area which it operates pursuant to a contract entered into under Article 2.91 (commencing with

Section 14089 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(3) A county organized health system as defined in Insurance Code Section 12693.05, in the county in which it provides comprehensive health care to eligible Medi–Cal beneficiaries.

(4) A local initiative as defined in Insurance Code Section 12693.08, in the region in which it provides comprehensive health care to eligible Medi–Cal beneficiaries.

(cc) "Participating plan" means a participating health, participating dental or participating vision care plan.

(dd) "Participating vision care plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the board to provide coverage to program subscribers:

(1) A vision insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(ee) "Program" means the Healthy Families Program.

(ff)(1) "Qualified alien" means an alien who, at the time he or she applies for, receives, or attempts to receive program benefits, is, under Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (8 U.S.C. Section 1641), any of the following:

(A) An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA) (8 U.S.C. Section 1101 et seq.).

(B) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. Section 1158).

(C) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. Section 1157).

(D) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. Section 1182 (d)(5)) for a period of at least one year.

(E) An alien whose deportation is withheld under Section 243(h) of the INA (8 U.S.C. Section 1253(h), as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division C of Public Law 104–208, or Section 241(b)(3) of such Act (8 U.S.C. Section 1251(b)(3)) (as amended by Section 305(a) of Division C of Public Law 104–208).

(F) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980 (8 U.S.C. Section 1153(a)(7)). (See editorial note under 8 U.S.C. Section 1101, "Effective Date of 1980 Amendment.")

(G) An alien who is a Cuban and Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980) (8 U.S.C. Section 1522nt.).

(H) An alien who, under Section 431(c)(1) of PRWORA (8 U.S.C. Section 1641 (c)(1)), meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien has been approved or has a petition pending which sets forth a prima facie case for any of the following:

a. Status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(ii), (iii) or (iv)).

b. Classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154 (a)(1)(B)(ii)or (iii)).

c. Cancellation of removal under Section 240A of the INA (8 U.S.C. Section 1229b) (as in effect prior to April 1, 1997).

d. Status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154(a)(1)(B)(i)).

e. Cancellation of removal pursuant to Section 240A(b)(2) of the INA (8 U.S.C. Section 1229b(b)(2)).

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(I) An alien who, under Section 431(c)(2) of the PRWORA (8 U.S.C. Section 1641 (c)(2)), meets all of the conditions of subparagraphs 1., 2., 3., 4. and 5. below:

1. The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty.

2. The alien did not actively participate in such battery or cruelty.

3. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

4. The alien meets the requirements of subparagraph (H)(3) above.

5. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(J) An alien child who meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien child meets the requirements of subparagraph (H)(3) above.

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(2) For purposes of subparagraphs (1)(H), (1)(I), and (1)(J), there is a "substantial connection between such battery or cruelty and the need for benefits to be provided" if the alien declares, and the program verifies, any of the following circumstances:

(A) The alien or the alien's child is receiving cash assistance based on the battery or extreme cruelty.

(B) The benefits are needed due to a loss of financial support resulting from the alien's and/or his or her child's separation from the abuser.

(C) The benefits are needed because the alien or his or her child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or cruelty.

(D) The benefits are needed to provide medical care during an pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien or his or her child, and/or to care for any resulting children.

(E) The medical coverage and/or health care services are needed to replace medical coverage or health care services the applicant or child had when living with the abuser.

(3) An alien who is a qualified alien pursuant to subparagraphs (1)(H), (1)(I), or (1)(J), will remain eligible for the program as long as the need for benefits related to the battery or cruelty is necessary as determined by the program, and the alien continues to meet all other program eligibility requirements. The program shall review the alien's circumstances to evaluate the subscriber's continued need for program benefits at the annual eligibility review.

(gg) "Qualifying event" means one of the following situations in which a child–linked adult may enroll in the program:

(1) A subscriber child through whom the child–linked adult is eligible enrolls in no–cost Medi–Cal or the program and the child–linked adult requests enrollment at the same time as the child. If the child–linked adult is not the applicant on behalf of the subscriber child, the child–linked adult may request enrollment within 2 months of the subscriber child's enrollment in no–cost Medi–Cal or the program.

(2) A subscriber child through whom the child–linked adult is eligible qualifies for an additional year of coverage under no–cost Medi–Cal or the program pursuant to Section 2699.6625 and the child–linked adult requests enrollment at the time of the child's annual eligibility review. If the child–linked adult is not the applicant on behalf of the subscriber child, the child–linked adult may request enrollment within 2 months of the subscriber child's qualification for an additional year of coverage through no–cost Medi–Cal or the program.

(3) A child–linked adult loses no–cost Medi–Cal coverage and requests enrollment within 2 months after notification of this loss of coverage.

(4) A subscriber child turns 19 and qualifies to participate in the program as a subscriber parent, and requests enrollment within 2 months of his or her 19th birthday.

(5) A child–linked adult has lost or will lose coverage under employer sponsored coverage as a result of one of the following and the child–linked adult requests enrollment within 2 months of the termination of coverage.

(A) The child–linked adult or other individual through whom the child–linked adult was covered lost employment or experienced a change in employment status.

(B) The child–linked adult or other individual through whom the child–linked adult was covered changed address to a zip code that is not covered by the employer–sponsored coverage.

(C) The employer of the child–linked adult or other individual through whom the child–linked adult was covered discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents.

(D) Death of the individual through whom the child–linked adult was covered, or a legal separation or divorce from the individual through whom the child–linked adult was covered.

(E) The child–linked adult was covered under a COBRA policy, and the COBRA coverage period has ended.

(6) A subscriber parent's period of disqualification pursuant to Subsection 2699.6611(d) has expired and enrollment is requested within 2 months of the end of the period of disqualification.

(7) The household income for a child–linked adult falls to a level at or below 200% of the federal poverty level and the child–linked adult requests enrollment within 2 months of this change in income.

(8) A subscriber parent marries and his or her spouse requests enrollment within 2 months of newly obtaining the status of a child–linked adult.

(9) A subscriber child begins living in the home with a parent, caretaker relative, or legal guardian and the parent, caretaker relative, or legal guardian requests enrollment within 2 months of newly obtaining the status of a child–linked adult.

(10) The program informs a child–linked adult who previously applied at a time when the program was closed to new enrollment that he or she may apply and he or she requests enrollment within 2 months of notification of the program's opening to new enrollment for child–linked adults.

(hh) "Rural demonstration projects" means health, dental and vision plan projects approved by the Board to address the unique access needs of special population and/or residents of rural medical service study areas.

(ii) "Rural Medical Service Study Area" means an area with (1) a population density of less than 250 persons per square mile; and (2) no town with a population in excess of 50,000 within the area, as determined by the Office of Statewide Health Planning and Development.

(jj) "Seasonal worker" means an individual whose principal employment is in agriculture, fishing and/or forestry, on a seasonal basis, as opposed to year–round employment; and who, for purposes of employment, does not establish a temporary place of residence. Seasonal workers commute to work in the area of their permanent address. Such employment must have been within the last twenty–four months.

(kk) "Special population" means seasonal workers, migratory workers or American Indians.

(*ll*) "State Supported Services" means abortions that are not the result of incest or rape, and are not necessary to save the life of the mother.

(mm) "Stepparent" means a person who is married to the parent of a child and who is not the other parent of the child.

(nn) "Subscriber" means either a "subscriber child" or a "subscriber parent."

(oo) "Subscriber child" means a person age 18 or a child who is eligible for and participates in the program.

(pp) "Subscriber parent" means a child–linked adult age 19 or over who is eligible for and participates in the program.

(qq) Tenses, and Number. The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

HISTORY

1. New chapter 5.8 (sections 2699.6500–2699.6815), article 1 (section 2699.6500) and section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsections (i), (k) and (o)(2)–(4) and amendment of NOTE filed 12–14–98 as an emergency; operative 12–14–98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–13–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–14–98 order transmitted to OAL 3–25–99 and filed 5–6–99 (Register 99, No. 19).
5. Amendment of subsection (s)(J)(3) filed 5–26–99 as an emergency; operative 5–26–99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–23–99 or emergency language will be repealed by operation of law on the following day.
6. New subsections (a), (o) and (v)–(y), subsection relettering, and amendment of NOTE filed 8–5–99 as an emergency; operative 8–5–99 (Register 99, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–3–99 or emergency language will be repealed by operation of law on the following day.
7. Amendment of newly designated subsection (j) filed 8–5–99 as an emergency; operative 8–5–99 (Register 99, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–3–99 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 5–26–99 order transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
9. Certificate of Compliance as to 8–5–99 order (amending subsection (j)) transmitted to OAL 11–2–99 and filed 12–1–99 (Register 99, No. 49).
10. Certificate of Compliance as to 8–5–99 order (adopting new subsections (a), (o) and (v)–(y), relettering subsections, and amending NOTE) transmitted to OAL 10–29–99 and filed 12–3–99 (Register 99, No. 49).
11. Amendment of subsections (d), (*l*) and (m) and amendment of NOTE filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
12. New subsection (b) and subsection relettering filed 3–21–2000 as an emergency; operative 3–21–2000 (Register 2000, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–19–2000 or emergency language will be repealed by operation of law on the following day.
13. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
14. Amendment of subsection (k) filed 6–20–2000 as an emergency; operative 6–20–2000 (Register 2000, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–2000 or emergency language will be repealed by operation of law on the following day.
15. Certificate of Compliance as to 3–21–2000 order transmitted to OAL 6–23–2000 and filed 7–17–2000 (Register 2000, No. 29).
16. New subsection (j), subsection relettering and amendment of NOTE filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
17. Certificate of Compliance as to 6–20–2000 order transmitted to OAL 10–12–2000; disapproval and reinstatement of text as it existed prior to emer-

gency amendment pursuant to Government Code section 11349.6(d) filed 11–27–2000 (Register 2000, No. 48).
18. Amendment of subsection (*l*) filed 11–28–2000 as an emergency; operative 11–28–2000 (Register 2000, No. 48). A Certificate of Compliance must be transmitted to OAL by 3–28–2001 or emergency language will be repealed by operation of law on the following day.
19. Certificate of Compliance as to 11–28–2000 order transmitted to OAL 1–31–2001 and filed 2–20–2001 (Register 2001, No. 8).
20. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
21. Certificate of Compliance as to 4–29–2002 order, including further amendment of subsections (i)(1), (3) and (4), (o)–(o)(1), (s)(4), (x) and (ee)(5)(E), transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
22. Amendment of subsection (n), new subsection (jj) and subsection relettering filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
23. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).
24. New subsections (a) and (c) and subsection relettering filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
25. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
26. Amendment of subsection (r) filed 3–27–2008 as an emergency; operative 3–27–2008 (Register 2008, No. 13). A Certificate of Compliance must be transmitted to OAL by 9–23–2008 or emergency language will be repealed by operation of law on the following day.

Article 2. Eligibility, Application, and Enrollment

§ 2699.6600. Application.

(a) To apply for the program:

(1) An applicant shall submit all information, documentation, and declarations required in subsection (c) of this section.

(2) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment of a person under age 19:

(A) Family child contributions owed on behalf of any person under age 19 for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(3) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment of a person age 19 or over:

(A) Family contributions owed on behalf of any person for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(C) Family parent contributions owed on behalf of a person for whom the applicant is requesting coverage for coverage provided on or after the person's 19th birthday.

(4) The program application, entitled "Family Health Coverage Mail–In Application, for Medi–Cal and Healthy Families" (MC321 HFP, 4/06), is hereby incorporated by reference. Alternatively, the program shall utilize the on–line application submitted electronically via the internet and the school lunch application and any supplemental forms received pursuant to Section 14005.41 of the Welfare and Institutions Code to make an eligibility determination.

(b) The applicant shall sign and date the following declaration: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this Application and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the Application Instructions, the declarations, and all information printed on this Application.

(c)(1) The application shall contain the following:

(A) The applicant's full name.

(B) The applicant's date of birth.

(C) The applicant's primary written and oral language.

(D) The home and mailing address for the applicant and for all persons for whom application is being made, the applicant's county of residence and phone number(s), and the applicant's e–mail address (optional).

(E) An indication of whether the applicant is over the age of 18 years and applying on behalf of a child or children, and/or on behalf of a child–linked adult. An indication of whether the applicant is an 18 year old applying on his or her own behalf; the applicant is an emancipated minor applying on his or her own behalf; the applicant is a minor who is not living in the home of a parent, legal guardian, caretaker relative, foster parent, or stepparent and is applying on his or her own behalf; or the applicant is a minor who is applying on behalf of his or her child.

(F) For each person for whom the applicant is applying, the following information is requested:

1. name (first, middle and last) including full birth name if different (not required for a child not yet born)
2. marital status and spouse's name
3. birth date (not required for a child not yet born)
4. birth place (not required for a child not yet born)
5. mother's first and last name and whether living in the child's household (optional for a person age 19 or over)
6. father's first and last name if living in the child's household (optional for a person age 19 or over)
7. an indication of whether the mother and father are deceased or disabled (optional for a person age 19 or over)
8. gender (not required for a child not yet born)
9. Social Security Number (optional)
10. ethnicity (optional unless the person is an American Indian),
11. relationship to applicant.
12. if the person lives away from home (optional for a person age 19 or over)
13. if the person is going to school
14. if the person has a physical, mental or emotional disability
15. if any person in the home is pregnant and if so, the expected due date

(G) A declaration that the applicant is applying to enroll in the program all of the applicant's eligible children who are not already enrolled in the program, unless the applicant is applying only on his or her own behalf.

(H) An identification of individuals living together in the home and their relationships. If an individual is pregnant, it should be indicated, along with the expected due date.

(I) A list of family members identified in (F) and (H) above, who live in the home and who had income in the previous or current calendar year.

1. If the applicant is a parent or stepparent, an 18 year old applying on their own behalf, a child–linked adult applying on his or her own behalf or that of another child–linked adult or a minor applying on his or her own behalf or on behalf of his or her child, for the household of each person applied for, the first, middle initial, last name, gender and date of birth of all family members living in the household, each person's relationship to the person applied for and their monthly income.

2. If the applicant is applying as a foster parent, caretaker relative, or legal guardian applying only on behalf of an 18 year old or a child, a statement of the monthly income of each person applied for, for whom they are a foster parent, caretaker relative, or legal guardian.

3. If the person for whom application is being made is a qualified alien with an affidavit of support pursuant to section 213A of the Immigration and Naturalization Act, the calculation of household income must include the sponsor's income as set forth in Section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), unless the person is eligible pursuant to Insurance Code Section 12693.76.

(J) Beginning one year after the parental coverage start date, for each child–linked adult for whom application is being made, an indication of his or her qualifying event as defined in Section 2699.6500.

(K) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed pursuant to subsections (F) and (H) above, provide social security number (optional) and documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:

a. Federal tax return. If self–employed, a schedule C must be included. If a person with reported income on the federal tax return is a step–parent, the step–parent's W–2 form is required to determine the amount of income associated with the financially responsible parent of the child being applied for.

b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

2. For the current calendar year:

a. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

b. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

i. The employee's name.

ii. The employer's business name, business address, and phone number.

iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address, and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, "the information provided is true and correct."

d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share–of–cost Medi–Cal,

ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500, and

iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

3. If documentation pursuant to 1. or 2. cannot be provided, an affidavit of income written by hand by the recipient of the income. If the individual who receives the income is unable to write the affidavit by hand because of physical or literacy limitations, the individual will sign an affidavit written on his or her behalf with a mark (unless physically incapable) and include the printed name and signature of a witness. The affidavit of income shall include the following:

a. A statement of the amount and frequency of the income received,

b. A declaration that the individual cannot provide other documentation of his or her income at the time of application to the program and that the information provided is true and correct to the best of the individual's knowledge and belief,

c. An acknowledgment that the individual understands that the information contained in his or her affidavit may be subject to a verification by the State, and

d. The signature of the individual providing the affidavit of income and the date of signature.

(L) The name of each family member living in the home who pays court ordered child support, court ordered alimony, or health insurance and the monthly amount paid. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of court ordered child support and/or alimony paid, health insurance paid, and child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

(M) A declaration that each person for whom application is being made is not eligible for Part A and Part B of Medicare.

(N) A declaration that each person for whom application is being made is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(O) A declaration that the applicant will notify the program within 30 days of any change of home or mailing address of any person applied for who is accepted into the program and any change in the applicant's home or mailing address.

(P) A declaration that the applicant and each person for whom application is being made will abide by the rules of participation of the program.

(Q) A declaration that the applicant and each person for whom application is being made will abide by the rules and adhere to the policies and procedures, including dispute resolution processes, of any participating plan in which such persons are enrolled.

(R) For each person for whom application is being made, indicate current employer sponsored health coverage or employer sponsored health coverage that was terminated in the last three months, including the reason for and date of the termination.

(S) For each person for whom application is being made, the applicant's declaration that the person is:

1. a citizen or national of the United States, or

2. a qualified alien who entered the United States prior to August 22, 1996 or who entered on or after August 22, 1996 and meets one of the criteria listed in Subsection 2699.6607(e)(2)(B), or

3. a qualified alien who does not meet the criteria specified in subsection (S)2. above.

(T) For each declaration made pursuant to (S), documentation of the individual's status. If documentation is unavailable at the time of application, persons declaring a status listed under subsection (S) above may submit documentation within two months from the date of enrollment. If any person for whom application is being made was previously disen-

rolled pursuant to Section 2699.6611(a)(3), documentation for that person shall be submitted with the application.

(U) A declaration that each person for whom application is being made is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program but the employer contribution for dependent(s) is less than $10.

(V) A declaration that each person for whom application is being made is not an inmate in a public correctional institution, or a patient in an institution for mental illness.

(W) A declaration that the applicant gives permission for the program to verify family income, health coverage, immigration status of each person for whom application is being made, California residence and other facts stated in the application.

(X) For each person for whom application is being made, an indication of whether the person has other health, dental or vision insurance.

(Y) An indication of whether anyone has filed a lawsuit because of an accident or injury on behalf of any person for whom application is being made.

(Z) An indication of whether the applicant wants to apply for Medi–Cal coverage for any unpaid medical expenses in the last three months prior to application for any person for whom application is being made.

(AA) The applicant shall provide all of the following:

1. A declaration that the applicant has reviewed the benefits offered by the participating health, dental and vision plans.

2. A declaration that the applicant agrees to pay the required family contribution for a period of six months, unless the applicant has a family contribution sponsor.

(BB) The applicant may provide the following optional information:

1. The applicant's choice of participating health, dental and/or vision plans.

2. The applicant's choice of primary care provider/clinic and provider/clinic code, and dentist/clinic and dentist/clinic code for the person(s) for whom application is being made.

3. An indication of whether there is more than one car in the children's household.

4. An indication of whether there is more than $3,150 cash in bank accounts in the children's household.

5. An indication if the applicant does not want the application reviewed for eligibility for Medi–Cal or the Program.

(CC) If assistance in completing the application was provided by an eligible individual, a statement by the applicant that such assistance was provided.

(DD) If applicable, a declaration that the applicant is a migratory worker or seasonal worker as defined in Section 2699.6500.

(EE) If applicable, the applicant's signed authorization that the program may release information over the telephone about the application status of the individual(s) applied for by the applicant to a representative of the enrollment entity designated by the applicant on the application. This permission will end on the date the program mails the results of the eligibility determination on this application.

(FF) If the applicant received assistance from a certified application assistant, the applicant's signed authorization (if applicable) that the program may release information notifying the entity with whom the certified application assistant is affiliated of the applicant's Annual Eligibility Review date.

(GG) If an applicant or the person for whom application is being made is American Indian or Alaska Native, acceptable documentation must be submitted to exempt the applicant from family contribution payments and benefit copayments. The exemption from family contributions and benefit copayments shall occur after receipt of such documentation. Notwithstanding the previous sentence, the exemption from family contributions will begin on the date of enrollment and continue for two months pending the receipt of acceptable documentation. If acceptable documentation is not received at the end of the two month exemption period, the appropriate family contribution will be assessed pursuant to Subsection 2699.6813(a). The applicant must indicate on the application that he or she is requesting a waiver of the family contributions. Acceptable documentation for the applicant or the child includes:

1. An American Indian or Alaskan Native enrollment document from a federally recognized tribe, or

2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, or

3. A letter of Indian heritage from an Indian Health Service supported facility operating in the State of California.

(HH) An indication of how the applicant learned about Medi–Cal and the program.

(II) An indication whether the applicant would like information sent to them regarding the Child Health and Disability Prevention Program (CHDP) for children and youth or the Women, Infants and Children (WIC) program.

(2) The Social Security numbers and other personal information are needed for identification and administrative purposes.

(d) For children referred pursuant to Section 14005.41 of the Welfare and Institutions Code, the program shall use the following to make an eligibility determination:

(1) For each child for whom the applicant is applying, the child's school lunch application forwarded pursuant to Section 49557.2 of the Education Code and Section 14005.41 of the Welfare and Institutions Code; and

(2) Supplemental Form for Express Enrollment Applicants (MC 368 (06/05)); and

(3) A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

(A) For each person for whom application is being made, a statement that the person is eligible for share–of–cost Medi–Cal; and

(B) A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500; and

(C) A determination of the number of family members living in the household; and

(4) Any additional information requested by the program pursuant to Subsection 2699.6600(c)(1)(C), (F)15., (G), (M)–(Q), (U)–(W), (AA), (BB)1.–2., (DD), (GG).

NOTE: Authority cited: Sections 12693.21, 12693.75 and 12693.755, Insurance Code; and Section 14005.41, Welfare and Institutions Code. Reference: Sections 12693.02, 12693.21, 12693.43, 12693.46, 12693.70, 12693.71, 12693.73, 12693.74, 12693.75 and 12693.755, Insurance Code.

HISTORY

1. New article 2 (sections 2699.6600–2699.6629) and section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 12–14–98 as an emergency; operative 12–14–98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–13–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–14–98 order transmitted to OAL 3–25–99 and filed 5–6–99 (Register 99, No. 19).
5. Amendment filed 5–26–99 as an emergency; operative 5–26–99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–23–99 or emergency language will be repealed by operation of law on the following day.
6. New subsection (c)(1)(EE) filed 8–5–99 as an emergency; operative 8–5–99 (Register 99, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–3–99 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 5–26–99 order transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
8. Certificate of Compliance as to 8–5–99 order, including new text for subsection (c)(1)(J), transmitted to OAL 10–29–99 and filed 12–3–99 (Register 99, No. 49).
9. Amendment of section and NOTE filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.

10. Amendment of subsection (a) and new subsections (c)(1)(FF)–(c)(1)(FF)3. filed 3–21–2000 as an emergency; operative 3–21–2000 (Register 2000, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–19–2000 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
12. Certificate of Compliance as to 3–21–2000 order, including further amendment of subsections (c)(1)(FF)2.–3., transmitted to OAL 6–23–2000 and filed 7–17–2000 (Register 2000, No. 29).
13. Amendment of subsections (a) and (c)(AA)3. filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
14. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
15. Certificate of Compliance as to 4–29–2002 order, including further amendment of subsections (c)(1)(N) and (c)(1)(EE), transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
16. Amendment of subsections (a)(3), (a)(4), (a)(5) and (c)(1)(Q), repealer of subsections (c)(1)(Z)4. and (c)(1)(BB) and subsection relettering filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).
18. Amendment filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
19. Certificate of Compliance as to 7–1–2004 order, including amendment of subsection (c)(1)(S)(3)., transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
20. Amendment of subsection (a)(3) filed 6–30–2005 as an emergency; operative 6–30–2005 (Register 2005, No. 26). Pursuant to Insurance Code section 12693.43(h), a Certificate of Compliance must be transmitted to OAL by 12–27–2005 or emergency language will be repealed by operation of law on the following day.
21. Certificate of Compliance as to 6–30–2005 order transmitted to OAL 10–5–2005 and filed 11–16–2005 (Register 2005, No. 46).
22. Amendment of subsection (a)(6), new subsections (d)–(d)(4) and amendment of NOTE filed 2–9–2006 as an emergency; operative 2–9–2006 (Register 2006, No. 6). Pursuant to subsection (c) of section 12693.75 of the Insurance Code, the adoption of this regulatory action is deemed an emergency, exempt from review by the Office of Administrative Law, and shall remain in effect for not more than 180 days unless readopted.
23. Certificate of Compliance as to 2–9–2006 order transmitted to OAL 7–21–2006 and filed 8–29–2006 (Register 2006, No. 35).
24. Amendments to subsection (a) deemed an emergency and exempt from OAL review pursuant to Section 75 of Chapter 74, Statutes of 2006, filed 7–31–2007; operative 7–31–2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–2008 or emergency language will be repealed by operation of law on the following day. Amendments of subsection (c)(1)(AA)(2) and (c)(1)(BB)(1) filed 7–31–2007 as an emergency; operative 7–31–2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–2008 or emergency language will be repealed by operation of law on the following day.
25. Certificate of Compliance as to 7–31–2007 order, including amendment of subsection (a)(4) operative 4–11–2008, transmitted to OAL 1–28–2008 and filed 3–12–2008 (Register 2008, No. 11).

§ 2699.6602. Early Applications.

An applicant may apply to the program in advance for persons who are not eligible at the time of application, but who the applicant believes will become eligible within three (3) months because of one of the following:

(a) They are currently enrolled in the Medi–Cal 200% Program and will become one year old.

(b) They are currently enrolled in the Medi–Cal 133% Program and will become age 6.

(c) They are currently on Medi–Cal for at least one month of continued eligibility under no cost, full scope Medi–Cal and have been notified by the county welfare office that coverage is ending.

(d) It is anticipated that the child will be born. When the child is born, an applicant must submit documentation of the child's birth to the program, and must include the child's name, place and date of birth, and gender. The documentation and information must be received by the program within thirty (30) days from the birth for a child to be eligible pursuant to this section. Acceptable forms of documentation include a certificate of birth provided by a hospital or other health care facility, a signed statement by the health practitioner who presided over the delivery, or an equivalent document.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.70 Insurance Code.

HISTORY

1. Renumbering of former section 2699.6603 to new section 2699.6602 filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).

§ 2699.6603. Board Determinations.

(a) If the Board makes a finding that sufficient funds are not available to cover the estimated costs of program expenditures and that it is necessary to limit enrollment in the program to ensure that expenditures do not exceed amounts available for the program, the program shall establish a waiting list.

(b) If the Board makes a finding that sufficient funds are not available to cover the estimated cost of program expenditures and that, in addition to limiting new enrollment in the program, it is necessary to terminate subscribers in the program to ensure that expenditures do not exceed amounts available for the program, subscriber children shall be disenrolled from the program at the end of the month of their anniversary date following their Annual Eligibility Reviews. The program shall not effectuate disenrollments pursuant to this subsection unless it also has established a waiting list pursuant to subsection (a) of this section and is not currently enrolling additional children on the basis of new applications of Add–A–Person forms.

(c) If the Executive Director determines that sufficient funds are available to cover the estimated cost of program expenditures for all eligible subscriber children, the program shall cease the disenrollment of eligible subscriber children pursuant to subsection (b) of this section during Annual Eligibility Review.

(d)(1) If the Executive Director determines that in addition to sufficient funds for all eligible subscriber children, sufficient funds are available to cover the estimated cost of program expenditures for some or all children on the waiting list, the program shall review applications for children on the waiting list in the order of their effective dates on the waiting list.

(2) If the Executive Director determines that sufficient funds are available to cover the estimated costs of program expenditures, the program shall cease to operate a waiting list after processing the applications, including Annual Eligibility Review submissions, and Add–A–Person forms of all children on the waiting list.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.96, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsection (a) and new subsection (d) filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
5. Renumbering of former section 2699.6603 to section 2699.6602 and new section 2699.6603 filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).

§ 2699.6604. Waiting List for Children.

(a) If the program has established and is operating a waiting list pursuant to Section 2699.6603, children for whom the program has received applications or Add–A–Person forms shall be placed on the waiting list in the order their applications or Add–A–Person forms were received. A

child's effective date on the waiting list shall be the date on which the program received the child's application. An eligibility determination shall not be made until the Executive Director has made a determination pursuant to Section 2699.6603(d) and the applicant provides all supporting documentation pursuant to subsection (d)(2) of this section.

(b) If the Board makes a finding pursuant to Section 2699.6603(b), each subscriber child disenrolled at Annual Eligibility Review pursuant to Section 2699.6603(b) shall be placed on the waiting list and the subscriber child's effective date on the waiting list shall be his or her disenrollment date.

(c) When the program places a child on the waiting list pursuant to subsections (a) or (b) of this section, the program shall provide the applicant with written notification of the child's placement on the waiting list.

(d) When the Executive Director determines, pursuant to Section 2699.6603(d), that sufficient funds are available to cover some or all eligible children who are not currently enrolled, the program shall enroll the number of eligible wait–listed children for whom sufficient funds are available, as follows:

(1) (A) The program shall first enroll those children who are on the waiting list because they were disenrolled at Annual Eligibility Review pursuant to Section 2699.6603(b). The program shall enroll these children in the order of their effective dates on the waiting list, starting with those who have the earliest effective date.

(B) If and when there are no remaining children who are on the waiting list because they were disenrolled at Annual Eligibility Review pursuant to Section 2699.6603(b), the program shall, to the extent that sufficient funds are available, enroll additional wait–listed children in the order of their effective dates on the waiting list, starting with those who have the earliest effective date.

(2) When sufficient funds are available to enroll a child based on that child's placement on the waiting list, the program shall provide the applicant with written notification. In that notice, the program shall request any necessary information pursuant to Sections 2699.6600 and 2699.6606 and any updates to information that no longer is current, pursuant to Section 2699.6600. The program shall then make an eligibility determination in accordance with Sections 2699.6606 and 2699.6607 and shall enroll the child if he or she is eligible.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.96, Insurance Code

HISTORY

1. New section filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).

§ 2699.6605. Initial Review of Application for Child–Linked Adults.

(a) Upon receipt of an application or an Add a Person Application form, the program shall determine if there is funding available for additional enrollment of child–linked adults in the program.

(b)(1) If there is no funding available for coverage of child–linked adults and the Board estimates that the program will be closed to new enrollment of child–linked adults for less than six (6) consecutive weeks, applications will be reviewed for completeness as set forth in Section 2699.6606 below and if complete, for eligibility. For persons age 19 and over who are determined to be eligible, the program will retain the applicant's family parent contributions payment to use to enroll the eligible child–linked adult(s) in the program once a vacancy opens in the program. The applicant may request a refund of the family parent contributions payment but the child–linked adult for whom enrollment was requested will be removed from the program waiting list. Persons age 19 and over for whom application is being made who are determined to be eligible will be placed on a waiting list in the following categories:

(A) Child–linked adults with an annual household income after income deductions of up to and including 100 percent of the federal poverty level.

(B) Child–linked adults with an annual household income after income deductions greater than 100 percent and up to and including 150 percent of the federal poverty level.

(C) Child–linked adults with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) The waiting list will be maintained as follows:

(A) Child–linked adults in category (b)(1)(B) will be placed ahead of child–linked adults in category (b)(1)(C) on the waiting list. Child–linked adults in category (b)(1)(A) will be placed ahead of child–linked adults in category (b)(1)(B) on the waiting list.

(B) Within each category, persons for whom application is being made who are determined to be eligible will be listed in the order in which completed applications were received by the program.

(C) Each applicant shall be notified of placement on the waiting list. When a vacancy occurs or funds become available, whichever is applicable, persons for whom application is being made shall be enrolled in the order in which they appear on the waiting list.

(c) If there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more for child–linked adults, the program will so notify applicants on behalf of child–linked adults. The program will apply the family parent contributions to the family child contributions for that household unless the applicant request a refund of the family parent contributions. The program shall refund the applicant's family parent contributions if there is no subscriber child in the household. When funds become available, the program will notify these applicants that the program is opening for new enrollment. To request coverage when the program opens for new enrollment, an applicant who previously applied for enrollment for a child–linked adult when the program was closed to new enrollment for six (6) consecutive weeks or more will be required to submit a new application pursuant to Section 2699.6600.

(d) If there is funding available, or there is no funding available for coverage of child–linked adults but the Board estimates that the program will be closed to such new enrollment for less than six (6) consecutive weeks, the application shall be reviewed for completeness pursuant to Section 2699.6606.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 5–26–99 as an emergency; operative 5–26–99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–23–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 5–26–99 order, including further amendment of subsections (b)(1)–(3), transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
5. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
7. Amendment of section heading filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).

§ 2699.6606. Review of Applications for Completeness.

(a) All applications and Add a Person Forms shall be reviewed for completeness, except for applications, Add a Person Forms, and documentation solely applicable to child–linked adults if there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more.

(b) An application that is complete except for documentation required by Section 2699.6600(c)(1)(T) shall be considered complete.

(1) If the application is incomplete, a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a notice indicating the required information and documentation will be mailed. The applicant must provide all information and documentation necessary for the application to be complete within seventeen (17) calendar days from the date the application was received by the program, and the applicant will be so notified.

(2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.

(3) If the application is complete or is completed within seventeen (17) calendar days, it will be reviewed for an eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
3. Amendment of subsections (a)–(b) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.6607. Determination of Eligibility.

(a) Except as specified in Section 2699.6605, the program shall complete the application review process within ten (10) calendar days of receipt of the complete application or Add a Person Form unless the program is waiting for necessary information pursuant to Subsection 2699.6606(b)(1) and (2) or is requesting information pursuant to Subsection 2699.6600(c)(1)(BB)(1). For those applications, the program shall complete the application review process within twenty (20) calendar days of receipt of the original application or Add a Person Form.

(1) The program shall determine eligibility for each person age 18 or under based upon the criteria specified in Insurance Code Sections 12693.70, 12693.73 and 12693.76 and this section.

(2) The program shall determine eligibility for each person age 19 and over based on the criteria specified in this section. Notwithstanding any other provision of this Chapter, the first date on which any person age 19 or over shall be eligible for the program is the parental coverage start date. In addition to the criteria applicable to all potential subscribers, to be a child–linked adult eligible to participate in the program, a person age 19 or over must meet all the following requirements:

(A) Is not eligible for no–cost full–scope, or pregnancy–related, Medi–Cal or Medicare Part A and B at the time of enrollment in the program.

(B) Is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(C) Is in a family with an annual or monthly household income after income deductions of up to and including 200 percent of the federal poverty level. Any income deduction that is applicable to a child under Medi–Cal shall be applied in determining the annual or monthly household income.

(D) If a person age 19 or over for whom enrollment in the program is requested has an annual or monthly household income after income deductions of 100 percent of the federal poverty level or below, a letter or Notice of Action from the County Welfare Office issued within the last two (2) months must state that the individual is not eligible for no–cost Medi–Cal for a reason other than:

1. failure to provide information requested by Medi–Cal or
2. termination from no–cost Medi–Cal at his or her own request.

(E) Notwithstanding 2699.6607(a)(2)(D), legal guardians applying to the program for coverage with an annual household income after income deductions of 100 percent of the federal poverty level or below do not need to provide a Notice of Action from the County Welfare Office.

(F) Meets the definition of child–linked adult as defined in Section 2699.6500.

(G) Has a qualifying event as defined in Section 2699.6500 or applies pursuant to Section 2699.6631 for the first year following the parental coverage start date.

(3) If the program does not have the documentation required by Subsection 2699.6600(c)(1)(T), the person shall be temporarily deemed to meet citizenship or immigration criteria until such documentation is submitted or until the time for submitting documentation established in Subsection 2699.6600(c)(1)(T) has expired, whichever is sooner.

(b) The program shall disregard any stepparent's income in determining income eligibility for a stepchild.

(c) The program shall disregard any child's income in determining income eligibility for any other person.

(d) If any persons for whom application is being made currently have employer sponsored health coverage, these persons shall be determined ineligible. If employer sponsored health coverage was terminated for any persons for whom application is being made within the last three (3) months, these persons shall be determined ineligible, unless the reason for the termination is one of the following:

(1) The person through whom the employer sponsored coverage had been available either

(A) lost employment or experienced a change in employment status,

(B) changed address to a zip code that is not covered by the employer–sponsored coverage,

(C) lost health benefits because the person's employer discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents, or

(D) lost coverage because of death of the individual through whom the children or child–linked adults were covered, or a legal separation or divorce from the individual through whom the children or child–linked adults were covered.

(2) The person for whom application is being made was covered under a COBRA policy, and the COBRA coverage period has ended.

(3) The person for whom application is being made had coverage provided under an exemption authorized under subdivision (i) of Section 1367 of the Health and Safety Code.

(e)(1) Subject to paragraph (2) below, an alien shall only be eligible for the program if the alien is a qualified alien.

(2)(A) In any fiscal year that the annual Budget Act provides the necessary funding, a person who is a qualified alien shall not be determined ineligible solely on the basis on his or her date of entry into the United States. If the annual Budget Act does not provide the necessary funding, and except as provided in subparagraph (B) below, a person who is a qualified alien and who entered or enters the United States on or after August 22, 1996, is not eligible for a period of five years beginning on the date of the alien's entry into the United States with a status within the meaning of the term qualified alien.

(B) The limitation under paragraph (2)(A) above shall not apply to the following aliens:

1. An alien who is admitted to the United States as refugee under Section 207 of the Immigration and Naturalization Act (INA).

2. An alien who is granted asylum under Section 208 of the INA.

3. An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1230(h)) (as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division (C) of Public Law 104–208) or Section 241(b)(3) of the INA (8 U.S.C. Section 1251(b)(3) (as amended by Section 305(a) of Division C of Public Law 104–208).

4. An alien who is a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980.

5. An alien admitted to the United States as an Amerasian immigrant as described in Section 1612(a)(2)(A)(v.) of Title 8 of the United States Code.

6. An alien who is lawfully residing in any state and is any of the following:

a. A veteran (as defined in Section 101, 1101, or 1301, or as described in Section 107 of Title 38 of the United States Code) with a discharge characterized as an honorable discharge and not on account of alienage and who fulfills the minimum active–duty service requirement of Section 5303A(d) of Title 38 of the United States Code.

b. On active duty (other than active duty for training) in the Armed Forces of the United States.

c. The spouse or unmarried dependent child of an individual described in subparagraph a. or b. or the unremarried surviving spouse of an individual described in subparagraph a. or b. who is deceased if the marriage fulfills the requirements of Section 1304 of Title 38 of the United States Code.

(3) The program shall verify the status of any person for whom application is being made to confirm that the person is a citizen, a non–citizen national of the United States, or a qualified alien.

(f) If the applicant does not select a health, dental and/or vision plan and the person being applied for is eligible for the program, the program shall assign the health, dental and/or vision plan as follows:

(1) Automatic assignment of the health plan to the community provider plan. If the community provider plan is not available, alternate assignment to an available health plan; and/or

(2) Alternate assignment of the dental and/or vision plan.

(g) If application was made pursuant to Section 2699.6602(d), eligibility is contingent upon receipt by the program of documentation of the child's birth within thirty (30) days of the birth.

(h) Applicants will be notified in writing of the eligibility determination for each person applied for. If a person is determined ineligible the notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The family contribution for any persons determined ineligible which was included with the application shall be refunded. If appropriate, and if permission is given by the applicant, the application shall be forwarded to the Medi–Cal program for eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsection (a) filed 12–14–98 as an emergency; operative 12–14–98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–13–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–14–98 order transmitted to OAL 3–25–99 and filed 5–6–99 (Register 99, No. 19).
5. Amendment of subsections (a) and (e) filed 5–26–99 as an emergency; operative 5–26–99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–23–99 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–26–99 order, including further amendment of subsections (a) and (c), transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
7. Amendment of subsections (a) and (d)(1), new subsection (e) and subsection relettering filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–10–2000 order, including amendment of subsections (d)(2)(B)4. and (f), transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
9. Amendment of subsection (f) filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
10. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 4–29–2002 order, including new subsection (a)(2)E), subsection relettering and amendment of newly designated subsection (a)(2)(G) and subsection (d)(2), transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
12. Amendment of subsections (a)(1)–(2) and (e)(2)(B)5. filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
13. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).
14. Amendment of subsections (a) and (a)(3) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
15. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
16. Editorial correction of subsection (g) (Register 2007, No. 30).
17. Amendment of subsections (a) and (f) filed 7–31–2007 as an emergency; operative 7–31–2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–2008 or emergency language will be repealed by operation of law on the following day.
18. Amendment of subsection (g) filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
19. Certificate of Compliance as to 7–31–2007 order transmitted to OAL 1–28–2008 and filed 3–12–2008 (Register 2008, No. 11).
20. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).

§ 2699.6608. Enrollment of AIM Infants.

(a) An AIM infant, who is born prior to July 1, 2007, shall be enrolled without application when the program receives the required family child contribution beginning with the first full month of coverage pursuant to Section 2699.6613(g), and the following information about the infant from the AIM infant's mother at any time through the end of the eleventh month following the month of birth:

(1) Name; and

(2) Date of birth; and

(3) Sex.

(b) An AIM infant, who is born on or after July 1, 2007, shall be enrolled without application provided the infant is not enrolled in no–cost full scope Medi–Cal, meets the eligibility requirements pursuant to Section 2699.6607(d), and the following information about the infant from the AIM infant's mother is provided at any time through the end of the eleventh month following the month of birth. Coverage shall begin pursuant to Subsection 2699.6613(h).

(1) Name; and

(2) Date of birth; and

(3) Sex; and

(4) Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and

(5) Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reasons for termination.

(c) The program shall request information from the AIM infant's mother, on the AIM infant's weight at birth and primary care provider.

(d) In lieu of reporting by the AIM infant's mother, the program must also accept the information specified in subsections (a) and (c) from the AIM infant's mother's health plan or a health care provider that provided services to the AIM infant's mother or the AIM infant.

(e) Upon receipt of the family child contribution and the information specified in subsection (a), or the information as specified in subsection (b), the program shall automatically enroll the eligible infant in the same health plan within the Healthy Families Program that the AIM infant's mother is enrolled in through the AIM program.

(f) Automatic enrollment of AIM infants (born before July 1, 2007) is subject to payment of family child contributions and timely notification of the infant's birth as provided in (a).

(g) Enrollment of eligible AIM infants (born on or after July 1, 2007) is subject to timely notification of the infant's borth as provided in (b).

(h) Notwithstanding subsection (a) or (b) of this section, infants in need of immediate health care services will be immediately enrolled in the program if: (1) the AIM infant's mother's health plan notifies the program in writing of the need for services and provides the information specified in subsection (a) or (b) of this section; and (2) this written notification occurs no later than the 10th day of the second full calendar month of the infant's life. For infants enrolled pursuant to this subsection (h), the required family child contribution shall be billed to the AIM mother. If the required family child contribution is not paid, the provisions of this article concerning disenrollment for failure to pay the required family child contribution shall govern.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73, 12693.755 and 12693.756, Insurance Code.

HISTORY

1. New section filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7-1-2004 order transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).
3. Amendment deemed an emergency and exempt from OAL review pursuant to Section 75 of Chapter 74, Statutes of 2006, filed 7-31-2007; operative 7-31-2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-28-2008 or emergency language will be repealed by operation of law on the following day.
4. Amendment of subsections (a) and (b) filed 11-30-2007 as an emergency; operative 11-30-2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5-28-2008 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7-31-2007 order transmitted to OAL 1-28-2008 and filed 3-12-2008 (Register 2008, No. 11).
6. Certificate of Compliance as to 11-30-2007 order transmitted to OAL 5-28-2008 and filed 7-7-2008 (Register 2008, No. 28).

§ 2699.6609. Change of Address.

An applicant shall notify the program in writing within thirty (30) days of any change of the applicant's billing address or any change of residence of a person participating in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 2-20-98 as an emergency; operative 2-20-98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-22-98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-20-98 order transmitted to OAL 6-5-98 and filed 7-15-98 (Register 98, No. 29).

§ 2699.6611. Disenrollment.

(a) A subscriber shall be disenrolled from participation in the program if any of the following occur:

(1) The subscriber is found by the program to no longer be eligible during the annual eligibility review period.

(2) The Board has made a finding pursuant to Section 2699.6603(b) and subscriber children are disenrolled from the program at Annual Eligibility Review. Each subscriber child disenrolled pursuant to Section 2699.6603(b) shall be placed on the waiting list and the subscriber child's effective date on the waiting list shall be his or her disenrollment date.

(3) The subscriber child attains the age of 19. A subscriber child who attains the age of 19 will not be disenrolled from the program if he or she applies to the program pursuant to Section 2699.6600 and is determined to be eligible for the program as a subscriber parent pursuant to Section 2699.6607 before his or her effective date of disenrollment.

(4) A subscriber is determined by the program to not be a citizen, non-citizen national, or a qualified alien eligible to participate in the program or fails to provide documentation required pursuant to Subsection 2699.6600(c)(1)(T) within the required time period.

(5) The applicant fails to pay the required family contribution for the subscriber for two (2) consecutive calendar months.

(6) The applicant so requests in writing on behalf of himself or herself or on behalf of another subscriber for whom he or she applied.

(7) The applicant has intentionally made false declarations in order to establish program eligibility for any person.

(8) The applicant fails to provide the necessary information for the subscriber to be requalified.

(9) Death of a subscriber.

(10) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in no-cost Medi-Cal and has not enrolled in the program.

(11) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 did not enroll in no-cost Medi-Cal, or the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(12) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 attains the age of 19 and the subscriber parent has no other children enrolled in the program or no cost Medi-Cal.

(13) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 no longer lives with the subscriber parent and another adult with whom the child now lives applies and is found eligible for enrollment as a child-linked adult through the same child.

(14) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(b)(1) Prior to disenrolling a subscriber pursuant to (a)(5), the program shall provide written notification to the applicant no less than thirty (30) days prior to disenrollment. Such notice shall clearly indicate all of the following:

(A) The disenrollment will not occur if payment in full is made as required.

(B) If disenrollment for non-payment occurs, coverage will be terminated at the end of the second consecutive month for which the family contribution was not paid.

(2) Prior to disenrolling a subscriber pursuant to subsection (a)(2) of this section, the program shall provide written notification to the applicant no less than fifteen (15) days prior to disenrollment. Such notice shall clearly indicate all of the following:

(A) The reason for the disenrollment.

(B) The effective date of disenrollment.

(c) When a subscriber is disenrolled pursuant to (a) above, the program shall notify the applicant of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of disenrollment.

(3) The final day of coverage provided through the program.

(4) An explanation of the appeals process including the right to request continued enrollment pursuant to Section 2699.6612.

(d) Disenrollment pursuant to (a)(5) shall be effective as of the end of the second consecutive calendar month for which the required monthly contributions were not paid in full.

(e) Disenrollment pursuant to (a)(1), (a)(2) and (a)(8) shall be effective at the end of the month of the subscriber's anniversary date.

(f) Disenrollment pursuant to (a)(4) shall be effective at the end of the calendar month in which the conclusion of the two–month period falls pursuant to Subsection 2699.6600(c)(1)(T).

(g) Disenrollment pursuant to (a)(6) shall be effective at the end of the month in which the applicant's request was received. The applicant will be notified of the amount of family contribution due to the program for coverage through the subscriber's effective date of disenrollment.

(h) Disenrollment pursuant to (a)(7) shall be effective at the end of the month in which the determination was made.

(i) Disenrollment pursuant to (a)(3) and (a)(12) shall be effective on the last day of the month the subscriber child or the child through whom the subscriber parent became eligible as a child–linked adult attains the age of 19.

(j) Disenrollment pursuant to (a)(9) shall be effective at the end of the month in which death occurred.

(k) Disenrollment pursuant to (a)(10) shall be effective at the end of the month following the program's notification of the subscriber child's disenrollment from no–cost Medi–Cal.

(*l*) Disenrollment pursuant to (a)(11) shall be effective at the end of the month following the second month from the date in which the application was received.

(m) Disenrollment pursuant to (a)(13) shall be effective at the end of the month following the program's determination that the subscriber child has departed from the subscriber parent's household and is living with another adult who has applied for enrollment and is eligible as a child–linked adult through that same child.

(n) Disenrollment pursuant to (a)(14) shall be effective at the end of the month following the program's determination that the adult is no longer child linked.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.45, 12693.74, 12693.77, 12693.755, 12693.96, 12693.98 and 12693.981, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsection (f) filed 12–14–98 as an emergency; operative 12–14–98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–13–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–14–98 order transmitted to OAL 3–25–99 and filed 5–6–99 (Register 99, No. 19).
5. Amendment of subsections (a)(1) and (a)(3), new subsection (a)(8), amendment of subsection (d) and new subsection (i) filed 5–26–99 as an emergency; operative 5–26–99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–23–99 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–26–99 order, including further amendment of subsection (f), transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
7. New subsection (f), subsection relettering, and amendment of newly designated subsection (g) filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 1–10–2000 order, including amendment of subsections (e) and (f), new subsection (h) and subsection relettering, transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
9. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 4–29–2002 order, including further amendment of subsections (a)(10)–(11), new subsection (a)(13), amendment of subsection (n) and new subsection (p), transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
11. Amendment filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 7–31–2003 order, including further amendment of subsection (d), transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).
13. Amendment of subsections (a)(3) and (g) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
15. Amendment of subsection (e), repealer of subsection (f) and subsection relettering filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
16. Amendment of section and NOTE filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).
18. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–10–2008 (Register 2008, No. 28).

§ 2699.6612. Appeals.

(a) The following program decisions may be appealed to the board:

(1) A decision that an individual is not qualified to participate or continue to participate in the program.

(2) A decision that an individual is not eligible for enrollment or continuing enrollment in the program.

(3) A decision as to the effective date of coverage.

(b) An appeal shall be filed in writing with the program within sixty (60) calendar days of the date of the notice of the decision being appealed.

(c) Appeals shall be reviewed pursuant to the following process:

(1) First level appeals shall be filed with the program, and the program shall make a determination on the appeal within thirty (30) calendar days from the receipt of the appeal. The program shall notify the appellant in writing of the programs decision and that he or she may request a second level review by the Executive Director.

(2) Second level appeals shall be filed with the Executive Director within thirty (30) calendar days of the date of the notice of the determination concerning the first level appeal. The program may contact the appellant to get clarification and additional information to make a determination. The program shall notify the appellant in writing of the Executive Director's decision and that he or she may request an administrative hearing.

(3) As determined by the program, an administrative hearing shall be conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, or pursuant to the pre– and post–hearing procedures set forth in Article 3 (commencing with Section 1140) of Chapter 2 of Division 2 of Title 1 of the California Code of Regulations as modified by Section 12693.89 of the Insurance Code. Requests for administrative hearings shall be filed with the program within thirty (30) calendar days of receipt of the determination concerning the second level appeal.

(d) An appeal shall include all of the following:

(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed.

(2) A statement describing the issues that are being disputed.

(3) A statement describing the program statute, regulation, or other written representation of program policy that the program or board violated.

(4) A statement of the resolution being requested.

(5) Any other relevant information.

(e) An appellant may request continued enrollment while the appeal is being determined. The enrollment shall continue until a determination is made. Family contributions and copays are required during the continued enrollment period. An appeal that requests continued enrollment shall:

(1) Be limited to appeals filed pursuant to subsection (c)(1) of this section.

(2) Be filed in writing with the program within fifteen (15) calendar days of the date the notice of the decision being appealed.

(3) Meet all other requirements described in this section.

NOTE: Authority cited: Sections 12693.21 and 12693.41, Insurance Code. Reference: Sections 12693.85, 12693.86, 12693.87 and 12693.89, Insurance Code; and 42 CFR Section 457.1170.

HISTORY

1. New section filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).

§ 2699.6613. Starting Date of Coverage for Subscribers.

(a) Coverage shall begin for subscribers no later than ten (10) calendar days from the date the person is determined to be eligible unless any of the following applies:

(1) A person for whom application is being made is eligible for continued eligibility under no–cost, full scope Medi–Cal and that eligibility will continue for more than ten (10) calendar days from the date the person is determined to be eligible.

(2) Application is being made on behalf of a child less than 12 months of age for coverage to begin on the child's first birthday pursuant to Section 2699.6603(a).

(3) Application is being made on behalf of a child who is currently enrolled in the Medi–Cal 133 percent program.

(4) Application is being made on behalf of a newborn prior to birth.

(5) Payment of in arrears family contributions is required prior to enrollment of the person pursuant to Section 2699.6600(a)(2) or (3).

(6) The subscriber is an AIM infant.

(b) Coverage shall begin for subscribers under (a)(1) on the first day after the end of the subscriber's continued eligibility period under Medi–Cal.

(c) Coverage shall begin for subscribers under (a)(2) on their first birthday.

(d) Coverage shall begin for subscribers under (a)(3) on their sixth birthday.

(e) Coverage shall begin for subscribers under (a)(4) no less than eleven (11) calendar days but within thirteen (13) calendar days after the program receives documentation of the birth.

(f) Coverage shall begin for subscribers under (a)(5) no later than thirteen 13 calendar days from the date the program receives a payment for the complete amount of family contributions owed by the applicant.

(g) Coverage shall begin for subscribers pursuant to (a)(6), who are born before July 1, 2007, on the infant's date of birth.

(h) Coverage shall begin for subscribers pursuant to (a)(6), who are born on or after July 1, 2007, on the following day:

(1) On the infant's date of birth, so long as the subscriber is not enrolled in the no–cost full scope Medi–Cal program or employer sponsored health coverage on his/her birth date.

(2) After the subscriber's date of birth when the subscriber's no–cost full scope Medi–Cal program or employer sponsored health coverage ends.

(i) The program shall notify applicants in writing of health coverage enrollment dates for all persons determined to be eligible.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, Insurance Code

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. New subsections (a)(4) and (e) and subsection relettering filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
5. Amendment filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 4–29–2002 order, including further amendment of subsection (f), transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
7. New subsections (a)(6) and (g) and subsection relettering filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
9. Amendment deemed an emergency and exempt from OAL review pursuant to Section 75 of Chapter 74, Statutes of 2006, filed 7–31–2007; operative 7–31–2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–2008 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 7–31–2007 order transmitted to OAL 1–28–2008 and filed 3–12–2008 (Register 2008, No. 11).

§ 2699.6617. Additional Enrollments.

(a) To apply to the program for additional persons, the applicant shall submit an application pursuant to Section 2699.6600 or the "Add a Person Form" (HF FM 067 EN, 11/17/2003), which requests information pursuant to Section 2699.6600(b), 6600(c)(1)(A), (D), (F)1., (F)3., (F)11., (F)15., (I), (K), (L), (R), (S), and (T).

(b) Eligibility for the program will be determined pursuant to Section 2699.6607.

(c) The "Add a Person Form" (HF FM 067 EN, 11/17/2003), is hereby incorporated by reference.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
5. Amendment of subsections (a) and (c) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.6619. Transfer of Enrollment.

(a) A subscriber shall be transferred from one participating health, dental, or vision plan to another if any of the following occurs:

(1) The applicant so requests in writing because the subscriber no longer resides in an area served by the participating plan in which the subscriber is enrolled, and there is at least one other participating plan serving the area in which the subscriber now resides.

(A) If the program learns that the subscriber no longer resides in an area served by the participating health plan in which the subscriber is enrolled, but the applicant does not choose a new health plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the program learns that the subscriber no longer resides in an area served by the participating dental plan in which the subscriber is enrolled, but the applicant does not choose a new dental plan within thirty (30) days of a written notice from the program, the program will enroll

the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the program learns that the subscriber no longer resides in an area served by the participating vision plan in which the subscriber is enrolled, but the applicant does not choose a new vision plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(2) The applicant or the participating plan so requests in writing because of failure to establish a satisfactory subscriber–plan relationship and the Executive Director of the Board or designee determines that the transfer is in the best interests of the subscriber and the program, and there is at least one other participating plan serving the area in which the subscriber resides.

(3) The program contract with the participating plan in which the subscriber is enrolled is canceled or not renewed.

(A) If the applicant does not choose a new health plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the applicant does not choose a new dental plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the applicant does not choose a new vision plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(4) An open enrollment request is submitted pursuant to Section 2699.6621.

(5) An AIM infant subscriber has a sibling(s) that is enrolled in a different health plan and is transferred pursuant to subsection (f).

(b) A subscriber shall be transferred from one participating health plan to another if the applicant so requests in writing once within the first three (3) months from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(c) A subscriber shall be transferred from one participating dental or vision plan to another if the applicant so requests in writing once within the first thirty (30) days from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(d) If a subscriber is transferred pursuant to (a), (b), or (c) above, all other subscribers of the same applicant who live in the same household will also be transferred, unless the subscriber was transferred because the subscriber moved from the household.

(e) Transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days of approval of the request, or, if the transfer is pursuant to subsection (a)(3) above, shall take effect prior to the end of the contract. However, subscribers in inpatient facilities on the scheduled date of transfer shall not be transferred to a new health plan until the first day of the month following completion of their inpatient stay.

(f) The following provisions apply to the transfer of AIM infants from one participating health, dental, or vision plan to another:

(1) An AIM infant subscriber will be automatically transferred to the same health, dental, and vision plan that his or her sibling(s) is enrolled in, effective on the first day of the infant's third calendar month of birth, unless one of the following occurs:

(A) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant's sibling(s) be transferred to the infant's health plan, or

(B) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant remain with the current health plan and the sibling(s) remain with his or her current health plan. For siblings enrolled in different health plans, the applicant must choose the same health plan for all children living in the household during the Open Enrollment period after the AIM infant's first birthday.

(2) An AIM infant subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the date of the infant's birth and the infant subscriber has no sibling(s) in the program. The transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days after the approval of the request but not earlier than the third calendar month of the infant's enrollment in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, 12693.326 and 12693.51 Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of section and NOTE filed 10–23–2001; operative 11–22–2001 (Register 2001, No. 43).
4. New subsections (a)(5) and (f)–(f)(2) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.6621. Open Enrollment Period.

(a) The program shall provide for an annual open enrollment period of at least forty–five (45) calendar days. During this period, applicants may for any reason request that subscribers be transferred from one participating health, dental, or vision plan to another. Plan selection rules set forth in Section 2699.6623 apply for open enrollment.

(b) For each subscriber for whom an applicant is requesting to change plans during an open enrollment period, the applicant shall provide the following:

(1) Full name

(2) Address

(3) Social Security Number (optional)

(4) Home telephone number

(5) Current participating plan(s)

(6) New participating plan(s)

(7) The applicant's choice of primary care provider/clinic (optional) and dentist (optional) for each child for whom application is being made.

(8) A declaration that the applicant understands that a change of participating plans may result in a change in the required family contribution.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.51 Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98

or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).

§ 2699.6623. Choosing Plans.

(a) If all persons for whom the applicant applies live in the same household, the applicant shall enroll all persons in the same participating health plan, the same participating dental plan, and the same participating vision plan.

(b) If the persons for whom the applicant applies live in more than one household, the applicant shall enroll all persons living in each household in the same participating health plan, the same participating dental plan and the same participating vision plan.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21 Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6625. Annual Eligibility Review for Subscribers.

(a) Except as specified in (c), each subscriber will be re–evaluated annually prior to his or her anniversary date in the program to determine continued eligibility for the program. Applicants shall be notified of the annual eligibility review process at least sixty (60) calendar days prior to the anniversary date.

(b) Notwithstanding (a), as a condition of continuing coverage beyond the age of twelve (12) months, an applicant who enrolls an AIM infant into the program after nine months of age shall provide the information necessary to determine the infant's eligibility for ongoing coverage after the age of twelve (12) months at the time of enrollment.

(c) If subscribers for whom an applicant has applied have different anniversary dates, the annual eligibility review will be based on the anniversary date of the last subscriber to be enrolled, except as described in Subsection 2699.6631(f).

(d) To requalify, an applicant must provide to the program all of the following information which is required to reestablish eligibility: the applicant's name and account number as stated on their billing statement; name and address of each enrolled person, documentation of gross income of each enrolled person's household as described in Subsection 2699.6600(c)(1)(K), documentation of court ordered child support, and/or alimony paid, and child care and/or disabled dependent care expenses paid in order to determine income deductions as described in Subsection 2699.6600(c)(1)(L), an indication of any pregnant family member living in the home and her expected due date, and a statement indicating which person(s) is currently enrolled in an employer sponsored health insurance plan. To avoid a break in coverage, all required information must be submitted at least ten (10) calendar days before the end of the month in which the anniversary date falls.

(e) Continued eligibility will be determined pursuant to Sections 2699.6607 and 2699.6611(a)(2).

(f) Unless disenrolled pursuant to Section 2699.6611, persons shall continue to be considered eligible for the program for one year from the effective date of coverage, or if a later annual eligibility review date is established under (c), until that date.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, 12693.74 and 12693.96, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of section heading and section filed 5–26–99 as an emergency; operative 5–26–99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9–23–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 5–26–99 order transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
5. Amendment of subsection (d) filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
7. Amendment filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
9. Amendment of subsection (c) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 7–1–2004 order, including amendment of subsection (a), new subsection (b), subsection relettering and amendment of newly designated subsections (c) and (f), transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
11. Amendment of subsection (e) and NOTE filed 11–30–2007 as an emergency; operative 11–30–2007 (Register 2007, No. 48). A Certificate of Compliance must be transmitted to OAL by 5–28–2008 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 7–31–2007 order transmitted to OAL 1–28–2008 and filed 3–12–2008 (Register 2008, No. 11).
13. Certificate of Compliance as to 11–30–2007 order transmitted to OAL 5–28–2008 and filed 7–7–2008 (Register 2008, No. 28).

§ 2699.6629. Payment for Application Assistance.

(a) The program shall pay an application assistance fee to an eligible entity that assists an applicant in completing a program application or assists an applicant in completing annual eligibility review, if the following conditions are met:

(1) A child or a child–linked adult are enrolled or requalified as a result of the application;

(2) The request for payment is made in writing and specifies the entity to which the payment shall be made and includes:

(A) The certified application assistant identification number of the person who assisted the applicant.

(B) The entity identification number.

(3) The application includes a signed and dated declaration by the applicant stating that the certified application assistant helped the applicant complete the application.

(4) The certified application assistant has successfully completed a state–sponsored or approved training course, which may include continuing education courses.

(b) The following entities are eligible to receive application assistance fees:

(1) an insurance agent as defined in Section 31 of the Insurance Code, or a broker as defined in Section 33 of the Insurance Code;

(2) a licensed health care provider;

(3) a tax preparer as defined in Section 22251(a)(1)(A) of the Business and Professions Code;

(4) a licensed health care institution;

(5) a licensed health care clinic;

(6) a county department of public health, a city health department, or a county department that delivers health services;

(7) an Indian Health Service Facility;

(8) a school;

(9) a faith–based organization;

(10) a licensed day–care provider;

(11) a direct state Maternal and Child Health Contractor;

(12) a WIC Supplemental Food and Nutrition program for Women, Infants and Children;

(13) a Parent Teacher Organization;

(14) An organization meeting all of the following criteria:

(A) The organization has significant interaction with children or parents of children who represent the target market for the program or for children's Medi-Cal;

(B) The organization is not a licensed health, dental or vision plan, or an organization providing health, dental or vision care to children; and

(C) The organization has a federal tax identification number and is a bona fide non-profit entity as determined by the Internal Revenue Service.

(c) An incomplete request will not be processed for reimbursement; missing information cannot be submitted at a later date.

(d) The amount of the application assistance fee shall be as follows:

(1) Fifty ($50.00) dollars per successful mail-in application made pursuant to Section 2699.6600 where a child successfully enrolls in no-cost Medi-Cal or the program. If the application is submitted electronically via the internet, the fee shall be sixty ($60.00) dollars per successful application, effective July 1, 2006.

(2) Fifty ($50.00) dollars per successful mail-in application made pursuant to Section 2699.6600 where a child-linked adult successfully enrolls in no-cost Medi-Cal or the program when a request for enrollment is made at the same time for the child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500.

(3) If children or child-linked adults on one application are enrolled in no-cost Medi-Cal or the program, a fifty ($50.00) dollar payment will be made for the mail-in application for each program pursuant to (1) and (2). A sixty ($60.00) dollar payment will be made for each program pursuant to (1), effective July 1, 2006.

(4) Payment will only be made on one successful application for no-cost Medi-Cal and one successful application for the program per enrollment entity for a household in a year.

(5) Fifty ($50.00) dollars for a successful Annual Eligibility Review for the program, effective July 1, 2006.

(e) The program shall monitor the payment of application assistance fees to assure the integrity of the process.

(1) The program may determine at any time that an individual will no longer be eligible to be a certified application assistant and/or an entity will no longer be eligible to receive application assistance fees.

(2) Notice of such determination shall be provided within five (5) calendar days.

(f) Entities applying for application assistance fees and certified application assistants are prohibited from assisting applicants in choosing a health, dental, or vision plan for persons for whom application is being made. The person or entity may direct the applicant to that part of the program materials that describes health, dental, and vision plans. Nothing in this subdivision shall be construed to prohibit an application assistant or entity from providing factual information comparing, contrasting, and explaining the differences between plans and/or provider networks when assisting an applicant. In no instance may an application assistant or entity suggest which plan or provider an applicant should choose.

(g) Participating dental and vision plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, or from assisting applicants to apply for the program except as permitted by California Insurance Code Section 12693.325.

(h) Participating health plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, or from assisting applicants to apply for the program except as permitted by California Insurance Code Section 12693.325.

(i) Nothing in this section shall prohibit licensed health, dental or vision care providers who are not claiming an application assistance fee from otherwise distributing program applications and providing assistance to applicants.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.32, 12693.325 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2-20-98 as an emergency; operative 2-20-98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-22-98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-20-98 order transmitted to OAL 6-5-98 and filed 7-15-98 (Register 98, No. 29).
3. Amendment of subsection (a)(3), repealer and new subsections (a)(3)(A)-(B), new subsections (a)(3)(C)-(G), and amendment of subsections (b)(1)-(2) and (d) filed 12-14-98 as an emergency; operative 12-14-98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4-13-99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12-14-98 order transmitted to OAL 3-25-99 and filed 5-6-99 (Register 99, No. 19).
5. Amendment filed 5-26-99 as an emergency; operative 5-26-99 (Register 99, No. 22). A Certificate of Compliance must be transmitted to OAL by 9-23-99 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5-26-99 order transmitted to OAL 9-17-99 and filed 10-28-99 (Register 99, No. 44).
7. Amendment of subsection (g), new subsection (h), subsection relettering and amendment of NOTE filed 10-23-2001; operative 11-22-2001 (Register 2001, No. 43).
8. Amendment of section and NOTE filed 4-29-2002 as an emergency; operative 4-29-2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10-28-2002 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 4-29-2002 order, including repealer of subsection (d)(4), subsection renumbering and amendment of newly designated subsection (d)(4), transmitted to OAL 10-28-2002 and filed 12-12-2002 (Register 2002, No. 50).
10. Amendment of subsections (d)(1)-(3) and (d)(5) deemed an emergency and exempt from OAL review pursuant to Section 75 of Chapter 74, Statutes of 2006, filed 7-31-2007; operative 7-31-2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-28-2008 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 7-31-2007 order transmitted to OAL 1-28-2008 and filed 3-12-2008 (Register 2008, No. 11).

§ 2699.6631. Initial Enrollment Period for Child-Linked Adults.

There shall be an initial enrollment period for child linked adults ending one year after the parental coverage start date. Thereafter, enrollment may only occur at a qualifying event as defined in Section 2699.6500.

(a) The program shall provide notification to the applicants of subscriber children enrolled prior to the parental coverage start date in households with incomes at or below 200 percent of the federal poverty level. Notification shall be sent to the address on record and shall include an explanation of program expansions to include child-linked adults, and instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(T), and the appropriate family contribution for enrollment.

(b) For the first year following the parental coverage start date, for all applications for the program for children only where one or more children enrolled in the program live in households with incomes at or below 200 percent of the federal poverty level, the applicant shall be notified of program expansions to include child-linked adults and shall be provided the opportunity to submit the additional information to the program. The notification shall include instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(T), and the appropriate family contribution for enrollment.

(c) For the first year following the parental coverage start date, the applicant shall be provided the opportunity to submit the form provided by the program pursuant to this section and the appropriate family contribution. Beginning one year after the parental coverage start date, applicants

must use an application or an Add a Person Form to request enrollment for a child or child–linked adult in the program.

(d) Except as provided in this section, the program shall determine eligibility and enroll child–linked adults pursuant to the process established for application to the program.

(e) Notwithstanding Section 2699.6625(e), the annual eligibility review date for the subscriber parent enrolled pursuant to Section 2699.6631 shall be the same as for the subscriber child through whom the subscriber parent became eligible.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

HISTORY

1. New section filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
3. Amendment of subsections (a)–(c) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

Article 3. Health, Dental and Vision Benefits

§ 2699.6700. Scope of Health Benefits.

(a) The basic scope of benefits offered by participating health plans must comply with all requirements of the Knox–Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.6703. No other benefits shall be permitted to be offered by a participating health plan as part of the program. The basic scope of benefits shall include:

(1) Health Facilities

(A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x–ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy, respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Inpatient hospital services. This includes coverage for general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

(B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes: physical, occupational, and speech therapy as appropriate; and those hospital services which can reasonably be provided on an ambulatory basis. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

General anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.

(2) Professional Services: Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

(A) Eye examinations: For subscriber children, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams. For subscriber parents, eye refraction is optional for plan.

(B) Hearing tests, hearing aids and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one–year period following the provision of a covered hearing aid.

Limitation: For subscriber parents, this benefit is limited to a maximum of $1000 per member every thirty–six months for the hearing instrument and ancillary equipment.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for

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correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered one–year warranty period, replacement of a hearing aid more than once in any period of thirty–six months, and surgically implanted hearing devices.

(C) Immunizations for subscriber children: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). Immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for subscriber parents: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

(D) Periodic health examinations: For subscriber children, periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the the Advisory Committee on Immunization Practices (ACIP).

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for subscriber parents: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations. This includes coverage for the screening and diagnosis of prostate cancer including but not limited to, prostate–specific antigen testing and digital rectal examination, when medically necessary and consistent with good medical practice. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(E)Well baby care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

(3) Diagnostic X–ray and Laboratory Services: Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow–up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, elecrocardiography, electro–encephalography, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A–1C (Glycohemoglobin).

(4) Prescription Drugs: Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, kerotine urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non–insulin dependent and gestational diabetes. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.

Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Health plans shall provide coverage for one cycle or course of treatment of tobacco cessation drugs per benefit year. The health plan must also require the subscriber to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

For subscriber parents, plans can require subscribers to pay a portion or all the cost of the smoking cessation classes or programs. Plans can also require the subscriber parent to pay the cost of the smoking cessation drug initially and reimburse the subscriber parent minus the copayment(s) upon the successful completion of a smoking cessation program.

Contraceptive Drugs and Devices: All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over–the–counter medicines, including non–prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), appetite suppressants or any other diet drugs or medications.

(5) Durable Medical Equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non–insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

(6) Orthotics and Prosthetics: Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her licensure. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics.

Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non–rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

(7) Cataract Spectacles and Lenses: Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.

(8) Maternity: Medically necessary professional and hospital services relating to maternity care including: pre–natal and post–natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

(9) Family Planning: Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

(10) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through the "911" emergency response system.

Non–emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when:

(A) medically necessary, and

(B) requested by a plan provider, and

(C) authorized in advance by the participating health plan.

Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

(11) Emergency Health Care Services: Twenty–four hour emergency care for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the patient's health in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

This must be provided both in and out of the health plan service area and in and out of the health plan's participating facilities.

(12) Mental Health

(A) Inpatient: Mental health care during a certified confinement in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition. For subscriber children determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) of a child or for a serious mental disorder, pursuant to Section 5600.3 of the Welfare and Institutions Code, plans may limit services to 30 days per benefit year. Plans shall be responsible for identifying subscriber children who may be SED or may have a serious mental disorder and shall refer these individuals to their respective county mental health department for determination. For subscriber children who are determined as SED or as having a serious mental disorder by their county mental health department, participating plans shall provide up to 30 days of inpatient care and shall then refer these individuals to their county mental health department for continued treatment of the condition.

Except as limited pursuant to the previous paragraph for subscribers who are determined as SED or as having a serious mental disorder by their county mental health department, plans must provide services with no visit limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive–compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Plans may limit coverage to 30 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or for a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code. Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

(B) Outpatient: Mental health care when ordered and performed by a participating mental health professional. This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent the plan determines it is appropriate for the health and recovery of the child.

Plans must provide services with no visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive–compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. Plans shall be responsible for identifying subscriber children who may be SED or may have a serious mental disorder and shall refer these individuals to their county mental health department for determination. Notwithstanding the first sentence of this paragraph, participating plans shall refer subscriber children who are determined by their county mental health department as SED or as having a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code, to their county mental health department for treatment of the condition.

Plans must provide up to 20 visits per benefit year Plans may limit coverage to 20 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.

Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.

(13) Alcohol and Drug Abuse:

(A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Participating health plans shall offer at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.

(14) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost–effective when there is a choice among several medically appropriate alternative services or settings.

Exclusions: Custodial care.

(15) Skilled Nursing Care: Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24–hour per day basis; bed and board; x–ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

Exclusions: Custodial care.

(16) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hos-

pital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.

(17) Acupuncture and Chiropractic: These are optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. For subscribers, coverage is limited to a maximum of 20 visits each per benefit year for acupuncture and chiropractic. Plans may provide a combined chiropractic/acupuncture benefit with a minimum of 20 visits allowed for both disciplines.

(18) Biofeedback is an optional benefit which health plans may offer.

(19) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

(20) Health Education: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

(21) Hospice: The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include physical therapy, occupational therapy, speech therapy, short–term inpatient care, pain control, and symptom management.

The hospice benefit may include, at the option of the health plan, homemaker services, services of volunteers, and short–term inpatient respite care.

The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

(22) Transplants: Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants. Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

(23) Reconstructive Surgery: Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

(A) Improve function

(B) Create a normal appearance to the extent possible

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(24) Participating health plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating health plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS Program.

(25) Participating health plans shall be responsible for identifying subscriber children who are severely emotionally disturbed and shall refer these individuals to their county mental health department for continued treatment of the condition.

(b) This part shall not be construed to prohibit a plan's ability to impose cost–control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

(c)(1) The scope of benefits shall include all benefits which are covered under the California Children's Services (CCS) Program (Health and Safety Code Section 123800, et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the CCS Program to be eligible for benefits under that program, a participating health plan shall not be responsible for the provision of, or payment for, the particular services authorized by the CCS Program for the particular subscriber for the treatment of CCS eligible medical condition. All other services provided under the participating health plan shall be available to the subscriber.

(d)(1) The scope of benefits shall include benefits provided by a county mental health department to a subscriber child the department has determined is seriously emotionally disturbed pursuant to Section 5600.3 of the Welfare and Institutions Code.

(2) When a subscriber child is determined by a county mental health department to be seriously emotionally disturbed pursuant to Section 5600.3 of the Welfare and Institutions Code, the participating health plan shall not be responsible for the provision of, or payment for, services provided by the county mental health department. This does not relieve the participating health plan from providing the mental health coverage specified in Section 2699.6700(a)(12).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60, 12693.61, 12693.62 and 12693.755, Insurance Code.

HISTORY

1. New article 3 (sections 2699.6700–2699.6721) and section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Editorial correction of article heading (Register 2001, No. 43).
4. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 4–29–2002 order, including amendment of subsections (a)(12)(A)–(B), transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6703. Excluded Health Benefits.

(a) Health benefit plans offered under this program shall exclude all of the following:

(1) Any services or items specified as excluded within Section 2699.6700.

(2) Any benefits in excess of limits specified in Section 2699.6700.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6700.

(4) Any services which are received prior to the subscriber's effective date of coverage.

(5) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:

(A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or

(B) Outmoded or not efficacious.

(6) Emergency facility services for non–emergency conditions.

(7) Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under Subsection 2699.6700(a)(7).

(8) Treatment for infertility is excluded. Diagnosis of infertility for subscribers is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

(9) Long–term care benefits including long–term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short–term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.6700 (a)(15) and (a)(21).

(10) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

(11) Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

(12) Cosmetic surgery that is solely performed to alter or reshape normal structures of the body in order to improve appearance.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsections (a)(8)–(a)(11), new subsection (a)(13) and amendment of NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order, including repealer of subsection (a)(10) and subsection renumbering, transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6705. Share of Cost for Health Benefits.

(a) Every participating health plan shall require copayments for benefits provided to subscribers, except as provided under federal law to subscribers who are American Indians receiving services at an Indian Health Service Facility, subject to the following:

(1) In any benefit year that the applicant has incurred $250 in health benefit copayments for services received by subscribers who live in one household and for whom the applicant applied to the program, the applicant shall be deemed to have met the copayment maximum.

(2) No deductibles shall be charged to subscribers for health benefits.

(3) The following specific copayments shall apply:

(A) Inpatient facility services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(B) Inpatient professional services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(C) Facility services on an outpatient basis for subscribers: No copayment, except for a $5 copayment per visit for Emergency Health Care Services. The emergency health care services copay is waived if the subscriber is hospitalized.

(D) Outpatient professional services: $5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.

(E) Outpatient mental health: $5 copayment per visit.

(F) Home health care: No copayment except for $5 per visit for physical, occupational, and speech therapy visits performed in the home.

(G) Alcohol and drug abuse: No copayment for inpatient services. $5 per visit for outpatient services.

(H) Hospice: No copayment for any services provided under this benefit.

(I) Transplants: No copayment for any services provided under this benefit.

(J) Physical, occupational, and speech therapy: No copayment for therapy performed on an inpatient basis. $5 copayment per visit for therapy performed in the home or other outpatient setting.

(K) Biofeedback, acupuncture, and chiropractic visits, when offered at the participating health plan's option: $5 copayment per visit. For subscriber parents, copayment of $5 for each biofeedback visit for mental health.

(L) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services; durable medical equipment, prosthetics and orthotics; blood and blood products; medical transportation services: No copayment.

(M) Hearing Aids: No copayment.

(N) Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. $5 per prescription for up to a 30–34 day supply for brand name or generic drugs, including tobacco use cessation drugs. For subscriber children, no copayment for FDA approved contraceptive drugs and devices including Norplant.

For subscriber parents, $5 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed. (Represents the copayment for oral contraceptives at $5 copay for each 90–day supply for the approximate number of months the medication will be effective).

Maintenance drugs: $5 copayment per 90–100 day supply either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

(4) Preventive services, including services for the detection of asymptomatic diseases, as defined by applicable Department of Managed Health Care regulations. These include:

(A) Periodic health exams; no copayment for subscriber children; $5 copayment per exam for subscriber parents.

(B) A variety of voluntary family planning services; no copayment for subscriber children. For subscriber parents $5 copayment per office visit.

Contraceptive services — no copayment for subscriber children. $5 copayment per visit and $5 copayment per device for subscriber parents.

(C) Prenatal care; no copayment.

(D) Vision and hearing testing; no copayment for subscriber children. For subscriber parents, $5 copayment per visit.

Eye refraction to determine the need for corrective lenses — no copayment for subscriber children. For subscriber parents, optional with $5 copayment per exam and limited to one visit per year.

(E) Immunizations; no copayment for subscriber children. $5 copayment per visit for subscriber parent.

(F) Venereal disease tests; No copayment for subscriber children. $5 copayment for subscriber parents.

(G) Cytology examinations on a reasonable periodic basis; no copayment for subscriber children. For subscriber parents, $5 copayment per exam.

(H) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the participating health plan or health care organizations affiliated with the participating health plan. No copayment for subscriber children.

For subscriber parents, up to $5 copayment for diabetes outpatient self-management training, education, and medical nutrition therapy services. Charge may vary for other education services.

(5) No copayment shall be charged to subscribers under 24 months of age for well baby care, health examinations and other office visits.

(6) No copayments shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native.

(7) Reconstructive Surgery — no copayment

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.615 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2-20-98 as an emergency; operative 2-20-98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-22-98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-20-98 order transmitted to OAL 6-5-98 and filed 7-15-98 (Register 98, No. 29).
3. New subsection (a)(6) filed 3-21-2000 as an emergency; operative 3-21-2000 (Register 2000, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-19-2000 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3-21-2000 order transmitted to OAL 6-23-2000 and filed 7-17-2000 (Register 2000, No. 29).
5. Amendment of section and NOTE filed 4-29-2002 as an emergency; operative 4-29-2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10-28-2002 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 4-29-2002 order transmitted to OAL 10-28-2002 and filed 12-12-2002 (Register 2002, No. 50).
7. Amendment of subsection (a)(6) filed 7-31-2003 as an emergency; operative 7-31-2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-27-2004 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 7-31-2003 order transmitted to OAL 11-17-2003 and filed 12-30-2003 (Register 2004, No. 1).
9. Amendment of subsection (a)(6) filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 7-1-2004 order transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).

§ 2699.6707. Annual or Lifetime Benefit Maximums.

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, 12693.60 and 12693.615, Insurance Code.

HISTORY

1. New section filed 2-20-98 as an emergency; operative 2-20-98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-22-98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-20-98 order transmitted to OAL 6-5-98 and filed 7-15-98 (Register 98, No. 29).

§ 2699.6709. Scope of Dental Benefits for Subscriber Children.

(a) The basic scope of benefits offered by a participating dental plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit.

No other dental benefits for subscriber children shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnostic and Preventive Benefits

(A) *Initial and periodic oral examinations.*

(B) Consultations, including specialist consultations.

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

3. Panoramic film x-rays are limited to once every 24 consecutive months.

(D) Prophylaxis services, limited as follows:

Not to exceed two in a twelve month period.

(E) Topical fluoride treatment.

(F) Dental sealant treatments, limited as follows:

Permanent first and second molars only.

(G) Space maintainers, including removable acrylic and fixed band type.

(H) Preventive dental education and oral hygiene instruction.

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are non-cosmetic.

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery

(A) Extractions, including surgical extractions

(B) Removal of impacted teeth, limited as follows:

1. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses.

(J) Post-operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure).

(4) Endodontics

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, limited as follows:

Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows:

Five quadrant treatments in any 12 consecutive months.

(C) Gingivectomy

(D) Osseous or muco-gingival surgery

(6) Crowns and Fixed Bridges

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three–quarter crown, and stainless steel. Related dowel pins and pin build–up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.

2. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

3. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

4. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within 36 consecutive months, unless:

a. it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or

b. the denture is unsatisfactory and cannot be made satisfactory

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited as follows:

One per arch in any 12 consecutive months.

(C) Denture repair.

(D) Denture adjustment.

(E) Tissue conditioning, limited to two per denture.

(F) Denture duplication.

(G) Implants are considered an optional benefit.

(H) Stayplates, limited as follows:

Stayplates are a benefit only when used as anterior space maintainers for children.

(8) Orthodontic Treatment, limited as follows:

If the subscriber child meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services program, benefits shall be provided and determined by the California Children's Services program.

(9) Other Dental Benefits

(A) Local anesthetics.

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or out–patient surgery setting is medically appropriate for dental services.

(10) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(11) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b)(1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63, 12693.64 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).

3. Amendment of section heading, section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6711. Scope of Dental Benefits for Subscriber Parents.

(a) The basic scope of benefits offered by a participating dental plan shall include all of the benefits and services listed in this section, subject to certain exclusions as listed.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefits.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnosis and Preventive Benefits

(A) Initial and periodic oral examinations — oral examinations are benefits only twice in a benefit year.

(B) Consultations, including specialist consultations

(C) Roentgenology, limited as follows:

1. Bitewing x–rays in conjunction with periodic examinations are limited to one series of four films in a benefit year.

2. Full mouth x–rays in conjunction with periodic examinations are limited to once in a three–year period unless special need is shown.

3. Panoramic film x–rays are limited to once in a three year–period.

(D) Prophylaxis services, not to exceed two in a twelve month period. A third cleaning will be provided as a benefit for high–risk patients in the following categories:

1. Women who are pregnant

2. Subscribers undergoing cancer chemotherapy

3. Subscribers with compromising systemic diseases such as diabetes as determined to be medically necessary for appropriate dental care by the provider and approved by the plan.

(E) Space maintainers, including removable acrylic and fixed band type.

(F) Preventive dental education and oral hygiene instructions

(2) Restorative Dentistry — amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay)

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are non–cosmetic

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build–up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery–extractions and certain other surgical procedures, including pre–and post–operative care.

(A) Extractions, including surgical extractions.

(B) Removal of impacted teeth. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post–operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure)

(4) Endodontics — treatment of tooth pulp

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, limited as follows. Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics — treatment of gums and bones that support the teeth

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingevectomy

(D) Osseous or muco–gingival surgery

Periodontal procedures which include cleanings are subject to the same limitations as other cleanings i.e., cleaning of any kind are benefits no more than twice in a benefit year except for high–risk patients as described in (a)(1)(D)1.

(6) Crown, Jackets, Cast and Fixed Bridges — crowns, jackets and cast restorations are benefits only if they are provided to treat cavities that cannot be restored with amalgam, synthetic plastic or resin fillings.

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three–quarter crown, and stainless steel. Related dowel pins and pin build–up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every five years.

2. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

3. Veneers posterior to the second biscupid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient's oral health and general dental condition permits.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is an optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within five years unless:

a. it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, there has been such an extensive loss of remaining teeth, or a change in supporting tissues, or

b. the denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within five years unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair, the plan determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissue that the existing appliance cannot be made satisfactory.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. The plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance (or established UCR fee). If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.

(C) Denture Repair

(D) Denture adjustment

(E) Tissue conditioning, limited to two per denture

(F) Denture duplication

(G) Implants (appliances inserted into bone or soft tissue in the jaw usually to anchor a denture) are covered.

(H) Stayplates — provided as a benefit only when used to replace extracted anterior teeth for adults during a healing period.

(8) Other Dental Benefits

(A) Local anesthetics

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(9) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(10) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b)(1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order, including new subsection (a) and redesignation of former subsections (a)–(t) to new subsections (a)(1)–(20), transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Renumbering of former section 2699.6711 to section 2699.6713 and new section 2699.6711 filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6713. Excluded Dental Benefits for All Subscribers.

(a) A dental benefits plan offered under this program shall exclude:

(1) Services which, in the opinion of the attending dentist, are not necessary to the subscriber's dental health.

(2) Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in Section 2699.6709 and 2699.6711.

(3) Cosmetic dental care.

(4) General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.

(5) Experimental procedures.

(6) Dental conditions arising out of and due to a subscribers employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

(7) Services which were provided without cost to the subscriber by State government or an agency thereof, or any municipality, county or other subdivisions.

(8) Hospital charges of any kind.

(9) Major surgery for fractures and dislocations.

(10) Loss or theft of dentures or bridgework.

(11) Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the subscriber became eligible for such services.

(12) Any service that is not specifically listed as a covered benefit.

(13) Malignancies.

(14) Dispensing of drugs not normally supplied in a dental office.

(15) Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.

(16) The cost of precious metals used in any form of dental benefits.

(17) The removal of implants.

(18) Services of a pedodontist/pediatric dentist for subscriber children except when a subscriber child is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel provider is a pedodontist/pediatric dentist.

(19) Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98

or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).

3. New subsection (d) filed 3–21–2000 as an emergency; operative 3–21–2000 (Register 2000, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–19–2000 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 3–21–2000 order transmitted to OAL 6–23–2000 and filed 7–17–2000 (Register 2000, No. 29).

5. Renumbering of former section 2699.6713 to section 2699.6715 and renumbering of former section 2699.6711 to section 2699.6713, including amendment of section heading, section and NOTE, filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 4–29–2002 order, including repealer of subsection (a)(8) and subsection renumbering, transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

(a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), "Diagnostic and Preventive Benefits."

(2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), "Restorative Dentistry."

(3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), "Oral Surgery", with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Soft tissue impaction — No copayment.

2. Bony impaction — $5 copayment per tooth.

(B) Root recovery — $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), "Endodontics", with the following exceptions:

(A) Root canal therapy $5 per canal.

(B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of $5 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $5 per canal.

(5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), "Periodontics", with the following exceptions:

(A) Osseous or muco–gingival surgery — $5 per quadrant.

(B) Gingivectomy — no copayment.

(6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), "Crowns and Fixed Bridges" with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of $5.

(B) Pontics are each subject to a copayment of $5.

(7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), "Removable Prosthetics", with the following exceptions:

(A) Dentures are subject to copayments as follows:

1. Complete maxillary denture — $5.

2. Complete mandibular denture — $5.

3. Partial acrylic upper or lower denture with clasps — $5.

4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles — $5.

5. Removable unilateral partial denture — $5.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline — No copayment.

2. Laboratory reline — $5.

(C) Denture duplication — $5.

(8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), "Orthodontia."

(9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), "Other".

(10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

(11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is $5.

(b) A fee of $5 shall be charged for failure to cancel an appointment without 24 hours prior notification.

(c) No deductibles shall be charged to subscriber children for dental benefits.

(d) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.63, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).

3. Renumbering of former section 2699.6715 to section 2699.6719 and renumbering of former section 2699.6713 to section 2699.6715, including amendment of section heading, section and NOTE, filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

5. Amendment of subsection (d) filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).

7. Amendment of subsection (d) filed 1–7–2005; operative 1–7–2005 (Register 2005, No. 1).

§ 2699.6717. Share of Cost for Dental Benefits for Subscriber Parents.

(a) Every participating dental plan shall require copayments for the dental benefits provided to subscriber parents subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(1), "Diagnostic and Preventive."

(2) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(2), "Restorative Dentistry", with the following exceptions:

(A) Micro filled resin restorations (non–cosmetic, acid etched, bonded, light cured):

1. $40 per surface

2. $65 for two or more surfaces

(3) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(3), "Oral Surgery", with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Partially bony impaction — $15 copayment.

2. Complete bony impaction — $15 copayment.

(B) Root recovery as a separate procedure — $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(4), "Endodontics" with the following exceptions:

(A) Root canal therapy (excluding restoration) is subject to copayments as follows:

1. 1 canal — $20

2. 2 canals — $40

3. 3 canals — $60

4. 4 canals — $80

(B) An apicoectomy performed in conjunction with filling or root canal therapy at the same time is subject to a copayment of $60 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $50 per canal.

(5) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(5), "Periodontics", with the following exceptions:

(A) Osseous or muco–gingival surgery is subject to a copayment of $150 per quadrant (includes post surgical visits).

(B) Gingivectomy is subject to a $5 copayment per tooth (fewer than six teeth).

(6) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(6), "Crowns and Bridges" (per unit), with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns (excluding molars) full crowns, or 3/4 crowns; are each subject to a copayment of $50. Cast post and core are subject to $40 per unit copayment, and bonded Maryland Bridge is subject to $50 copayment per unit.

(B) Pontics are each subject to a copayment of $50.

(7) "Removable Prosthetics" as listed under Subsection 2699.6711(a)(7) are subject to the following copayments:

(A) Dentures are subject to copayments as follows:

1. Complete upper denture (3 adjustments within 60 days) — $65.

2. Complete lower denture (3 adjustments within 60 days) — $65.

3. Partial acrylic upper or lower denture with clasps — $5.

4. Partial acrylic upper or lower denture with 2 chrome cobalt allow clasps is subject to a base fee of $65.

5. Partial lower or upper denture with chrome cobalt allow, lingual or palatal bar, clasps and acrylic saddles — $65 base fee (included two clasps).

6. Removable unilateral partial denture — $50.

7. Stayplate (maximum two teeth included) — $60.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline — No copayment.

2. Laboratory reline — $15 copayment.

(C) Denture duplication — $20 copayment.

(D) Denture Repairs

1. Adding teeth to partial denture to replace natural tooth:

First tooth — $10 copayment.

Each additional tooth — $5 copayment.

2. Broken partial denture (no teeth involved) Replacement broken clasp — $5 copayment.

3. Add clasp with rest — $5 copayment.

(8) Other Services After hour visit — $35 copayment.

Broken appointment — $5 copayment.

(9) Implants — If implants are utilized, the plan will apply the cost of a standard full or partial denture towards the cost of implants and appliances constructed thereon, and if performed, subscriber parent must pay the difference plus any applicable copayment. Surgical removal of implants is not covered.

(b) No deductibles shall be charged to subscriber parents for dental benefits.

(c) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or subscriber is American Indian or Alaska Native.

(d) Note: Any procedure not listed in the EOC is available on a fee–for–service basis.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Renumbering of former section 2699.6717 to section 2699.6721 and new section 2699.6717 filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
5. Amendment of subsection (c) filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).
7. Amendment of subsection (c) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.6719. Waiting Periods for Receipt of Specified Benefits.

Participating dental plans may not subject enrollees to waiting periods for receipt of specified benefits.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.63, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Renumbering of former section 2699.6719 to section 2699.6723 and renumbering of former section 2699.6715 to section 2699.6719 filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6721. Scope of Vision Benefits.

(a) The basic scope of benefits offered by a participating vision plan as a vision benefit plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

(1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

(A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.

(B) Evaluation of the health status of the visual system; including:

1. external and internal examination, including direct and/or indirect ophthalmoscopy;

2. assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;

3. biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;

4. screening of gross visual fields; and

5. pressure testing through tonometry.

(C) Evaluation of refractive status, including:

1. evaluation for visual acuity;

2. evaluation of subjective, refractive, and accommodative function; and

3. objective testing of a patient's prescription through retinoscopy.

(D) Binocular function test.

(E) Diagnosis and treatment plan, if needed.

(F) Examinations are limited to once each twelve month period, which begins with the date of the last exam.

(2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular lenses as appropriate.

Frames and lenses are limited to once each twelve month period, which begins with the date of the last exam.

(3) Contact lenses shall be covered as follows:

(A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:

1. following cataract surgery;
2. to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
3. certain conditions of Anisometropia; and
4. keratoconus.

(B) Elective contact lenses may be chosen instead of corrective lenses and a frame a maximum benefit allowance of $110, which includes examinations, fittings and lenses.

(C) Contact lenses are limited to once each twelve month period, which begins with the date of the last exam.

(4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a $5 copayment for any approved Low Vision services.

(5) Participating vision plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b)(1) The scope of vision benefits shall also include all vision benefits which are covered under the California Children's Services Program (Health and Safety Code Section 123800 et seq.) provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program to be eligible for vision benefits under that program, a participating vision plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating vision plan shall be available to the subscriber.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65, 12693.66 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. New subsection (d) filed 3–21–2000 as an emergency; operative 3–21–2000 (Register 2000, No. 12). A Certificate of Compliance must be transmitted to OAL by 7–19–2000 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–21–2000 order transmitted to OAL 6–23–2000 and filed 7–17–2000 (Register 2000, No. 29).
5. Renumbering of former section 2699.6721 to section 2699.6725 and renumbering of former section 2699.6717 to section 2699.6721, including amendment of section and NOTE, filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6723. Excluded Vision Benefits.

(a) A vision benefits plan offered under this program shall exclude:

(1) Benefits which are neither necessary nor appropriate.

(2) Benefits which are not obtained in compliance with the rules and policies of the subscriber's vision plan.

(3) Vision training.

(4) Aniseikonic lenses.

(5) Plano lenses.

(6) Two pairs of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.

(7) Replacement or repair of lost or broken lenses or frames and lenses or frames lost or broken prior to being eligible for services.

(8) Medical or surgical treatment of the eyes.

(9) Services or materials for which the subscriber is covered under a Worker's Compensation policy. The participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such benefits.

(10) Eye examinations required as a condition of employment.

(11) Services or materials provided by any other group benefit providing for vision care.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6719 to section 2699.6723, including amendment of section and NOTE, filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6725. Share of Cost for Vision Benefits.

(a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of the vision plan's panel of approved providers subject to the following:

(1) Examinations: $5 copayment per examination.

(2) Frames and lenses: $5 copayment, for frames with lenses, frames or lenses.

A wholesale frame allowance of $30 will be provided by the vision plan. If a subscriber chooses a frame with a wholesale value above $30, the provider will bill the subscriber the difference between the standard retail value of $75 for a $30 wholesale frame and the retail cost of the frame the subscriber has selected.

The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.

(A) Blended lenses (bifocals which do not have a visible dividing line);

(B) Contact lenses except as specified in Section 2699.6721(a)(3);

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions);

(D) Progressive multifocal lenses;

(E) Coated or laminated lenses;

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3): no copayment.

(4) Elective contact lenses: an allowance of $110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all bene-

fits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.

(5) Low vision benefits:

(A) Supplementary testing: No copayment; and

(B) Supplemental care: Copayment is $5.

(b) Services from providers not included in the vision plan's panel of approved providers:

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

(1) Professional fees:

(A) Vision exams, up to $35.00

(2) Materials:

(A) Each single vision lens, up to $12.50

(B) Each bifocal lens, up to $20.00

(C) Each trifocal lens, up to $25.00

(D) Each lenticular lens, up to $50.00

(E) Frame, up to $40.00

(F) Tint allowance, up to $5.00

(G) Each pair of necessary contact lenses, up to $250.00

(H) Each pair of elective contact lenses, up to $110.00. Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.

(3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

(c) No deductibles shall be charged to subscribers for vision benefits.

(d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment. Additional services selected for cosmetic purposes are the financial responsibility of the patient.

(e) No copayments shall apply if the applicant has submitted acceptable documentation as described in Section 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native. However, there is no limitation on the payments required under Subsection (b) above.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

HISTORY

1. Renumbering of former section 2699.6721 to section 2699.6725, including amendment of section and NOTE, filed 4-29-2002 as an emergency; operative 4-29-2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10-28-2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 4-29-2002 order transmitted to OAL 10-28-2002 and filed 12-12-2002 (Register 2002, No. 50).
3. Amendment of subsection (e) filed 7-31-2003 as an emergency; operative 7-31-2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-27-2004 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 7-31-2003 order transmitted to OAL 11-17-2003 and filed 12-30-2003 (Register 2004, No. 1).
5. Amendment of subsection (e) filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7-1-2004 order transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).

Article 4. Risk Categories and Family Contributions

§ 2699.6800. Risk Categories Dental and Vision.

(a) Subscriber child rates are as follows:

(1) Dental and vision benefits plan rates shall be based exclusively on one risk category: geographic region of the subscriber's residence. The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (2) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The Board may allow one or more dental and vision plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(3) Dental and vision plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of age or number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Dental and vision benefits plan rates shall be based exclusively on one risk category: geographic region of the subscriber's residence. The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (2) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The Board may allow one or more dental and vision plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(3) Dental and Vision plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of age or number of subscribers covered by one family contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

HISTORY

1. New article 4 (sections 2699.6800–2699.6815) and section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsection (a), new subsection (b) and subsection relettering filed 8–5–99 as an emergency; operative 8–5–99 (Register 99, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–3–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 8–5–99 order transmitted to OAL 11–2–99 and filed 12–1–99 (Register 99, No. 49).
5. Amendment of section heading and subsections (a), (b) and (c) filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
7. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6801. Risk Categories Health.

(a) Subscriber child rates are as follows:

(1) With the exception of rates applicable to AIM infants in the first two calendar months of life, health benefit plan rates shall be based on two risk categories: geographic region of the subscriber's residence and the age of the subscriber. Health plan benefit rates for subscribers entering the program as AIM infants shall initially be determined in accordance with subsection (c).

(2) The age categories for subscriber children shall be as follows:

(A) The first age category is subscribers under the age of one.

(B) The second age category is subscribers of the age of one and over.

(3) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (4) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(4) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(5) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of the number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and age of the subscriber parent.

(2) The age categories for subscriber parents shall be as follows:

(A) The first age category is subscribers under the age of forty–five.

(B) The second age category is subscribers age forty–five and over.

(3) Health plans shall also be paid an additional lump sum payment for each delivery of one or more newborns to a subscriber parent while enrolled in the program.

(4) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (5) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(5) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(6) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of number of subscribers covered by one family contribution.

(c) Subscriber Rates for AIM Infants

(1) The initial rate for subscribers entering the program as AIM infants shall be determined as follows:

(A) The rate shall be available only to health plans participating as contractors in the AIM Program and shall cover a health plan's entire service area.

(B) The rate shall cover the birth month through the end of the AIM infant's second month of life. After this period, a health plan shall be paid rates in accordance with the age and geographic region categories in subsections (a)(2), (3) and (4).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

HISTORY

1. New section filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).
3. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
5. Amendment of subsection (a)(1) and new subsections (c)–(c)(1)(B) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).

§ 2699.6803. Annual Health, Dental and Vision Benefit Plan Rates.

Health, dental and vision benefit plan rates shall be established for each contract term.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 3–27–2008 as an emergency; operative 3–27–2008 (Register 2008, No. 13). A Certificate of Compliance must be transmitted to OAL by 9–23–2008 or emergency language will be repealed by operation of law on the following day.

§ 2699.6804. Rural Demonstration Project(s) Payments.

In addition to plan rates, the Board may:

(a) Pay plan rates enhancement(s) to a health, dental or vision benefits plan based on the plan's participation in a rural demonstration project(s). Such rate enhancements shall be for the same period as the annual health, dental and vision benefit plan rates.

(b) Provide a grant(s) to a health, dental or vision plan based on the plan's participation in a rural demonstration project(s).

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.91, Insurance Code.

HISTORY

1. New section filed 8–5–99 as an emergency; operative 8–5–99 (Register 99, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–3–99 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–5–99 order transmitted to OAL 10–29–99 and filed 12–3–99 (Register 99, No. 49).

§ 2699.6805. Designation of Community Provider Plan.

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area which includes zip codes in which at least eighty–five percent (85%) of the residents of the county reside that has the highest percentage of traditional and safety net providers pursuant to the calculation in (e) below.

(b) By the end of November of each year, the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Care Services (DHCS) CHDP Master File as of October 1st of that year and which provided a State–Only Funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each provider, the list shall indicate the percentage of county children that received State–only funded CHDP services from the identified provider. The number of county children shall be calculated by summing the numbers of children that received State–only funded CHDP services from each listed provider.

(2) The clinic list shall include all community clinics, free clinics, rural health clinics, and county owned and operated clinics, located in the county, which were so identified by the Medi–Cal program as of October 1st of that year and which were identified on the Medi–Cal Paid Claims Tape as having provided service to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each clinic, the list shall indicate a percentage which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall include:

(A) For a county that has, located in the county, at least one hospital which was as of October 1st of that year a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health Care Services, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi–Cal, county indigent and charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. For each hospital, the list shall indicate the percentage of the Medi–Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals which discharged at least one resident of the county who was a Medi–Cal, county indigent or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the DHCS, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. For each hospital the list shall indicate the percentage of the Medi–Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(d) By January 15th of each year, each participating health plan shall submit to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to (c)(1) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to (c)(2) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to (c)(3) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the percentages assigned to all CHDP providers in the county identified by the plan pursuant to (d)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.

(3) The hospital percentage is calculated by summing the percentages assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

(f) The Board shall designate a community provider plan for each county for the benefit year described in subsection (a). Notwithstanding subsection (h) of section 2600.6500, the designation shall take effect on the day the open enrollment transfers described in section 2699.6621 take effect, and the previous designation shall remain in effect until that time. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall only be revised under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to (c)(1) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.

(2) Any clinic not included on a county list pursuant to (c)(2) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documen-

tation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.

(3) Any hospital not included on a county list pursuant to (c)(3) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.37, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of subsections (c)(2) and (c)(3)(A)–(B) filed 12–14–98 as an emergency; operative 12–14–98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–13–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–14–98 order transmitted to OAL 3–25–99 and filed 5–6–99 (Register 99, No. 19).
5. Amendment filed 6–20–2000 as an emergency; operative 6–20–2000 (Register 2000, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–2000 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–20–2000 order transmitted to OAL 10–12–2000; disapproval and reinstatement of text as it existed prior to emergency amendment pursuant to Government Code section 11349.6(d) filed 11–27–2000 (Register 2000, No. 48).
7. Amendment filed 11–28–2000 as an emergency; operative 11–28–2000 (Register 2000, No. 48). A Certificate of Compliance must be transmitted to OAL by 3–28–2001 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 11–28–2000 order transmitted to OAL 1–31–2001 and filed 2–20–2001 (Register 2001, No. 8).
9. Amendment of subsections (c)(1), (c)(3)(A)–(B) and (f) filed 3–27–2008 as an emergency; operative 3–27–2008 (Register 2008, No. 13). A Certificate of Compliance must be transmitted to OAL by 9–23–2008 or emergency language will be repealed by operation of law on the following day.

§ 2699.6807. Change of Risk Category.

When a subscriber changes county of residence as specified in Section 2699.6800, or transfers between health plans pursuant to Section 2699.6619, the family contributions amount shall be recalculated and changed as of the first of the following month, unless the applicant has a family contribution sponsor.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
4. Amendment filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6809. Determination of Family Contribution for the Program.

(a) Family child contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Seven dollars ($7) per subscriber child with a maximum required contribution of fourteen dollars ($14) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Through June 30, 2005, nine dollars ($9) per subscriber child with a maximum required contribution of twenty–seven dollars ($27) per month for subscriber children with annual household incomes after income deductions if greater than 150 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants. On and after July 1, 2005, these rates apply only for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(C) On and after July 1, 2005, fifteen dollars ($15) per subscriber child with a maximum required contribution of forty–five dollars ($45) per month for subscriber children with annual household incomes after income deductions greater than 200 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable, through the first year of eligibility, for subscribers who entered the program as AIM infants and for those AIM infants whose annual household income after deductions remains above 200 percent of the federal poverty level after each Annual Eligibility Review.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Four dollars ($4) per subscriber child with a maximum required contribution of eight dollars ($8) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level,

(B) Through June 30, 2005, six dollars ($6) per subscriber child with a maximum required contribution of eighteen dollars ($18) per month for subscriber children with annual household incomes after income deductions of greater than 150 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants. On and after July 1, 2005, these rates apply only for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(C) On and after July 1, 2005, twelve dollars ($12) per subscriber child with a maximum required contribution of thirty–six ($36) per month for subscriber children with annual household incomes after income deductions of greater than 200 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable, through the first year of eligibility, for subscribers who entered the program as AIM infants and for those AIM infants whose annual household income after income deductions remains above 200 percent of the federal poverty level after each Annual Eligibility Review.

(b) Family parent contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Ten dollars ($10) per month per subscriber parent with an annual household income after income deductions of up to and including 150 percent of the federal poverty level.

(B) Twenty dollars ($20) per month per subscriber parent with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Seven dollars ($7) per month per subscriber parent with an annual household income after income deductions of 150 percent of the federal poverty level.

(B) Seventeen dollars ($17) per subscriber parent with an annual household income after income deductions of greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Applicants who pay in advance the amount of three (3) months of family child contributions shall receive the fourth consecutive month of coverage for a subscriber child with no family child contributions required.

(d) Applicants who pay in advance the amount of three (3) months of family parent contributions shall receive the fourth consecutive month of coverage for a subscriber parent with no family parent contributions required if the subscriber child contributions (if applicable) are also paid in advance, at the same time for the same three month period.

(e) Applicants who pay the family child contributions (if applicable) and the family parent contributions (if applicable) by electronic fund transfer or scheduled credit card payment shall receive a twenty–five (25) percent discount off the monthly combined total of the family child contributions and family parent contributions.

(f) If the applicant is applying for children in more than one household, the income of the household with the lowest annual income after income deductions will be used to determine the family contributions.

(g) If an applicant has a family contribution sponsor, family child contributions and/or family parent contributions that are to be paid by the family contribution sponsor for any twelve (12) consecutive months in the program shall be established based on subsections (a) and (b) above.

(h) If an AIM infant is enrolled in a different health plan from his or her siblings until the Open Enrollment period after the AIM infant's first birthday, the family child contribution will be the family child contribution for the siblings, plus the contribution rate for one more child at the same rate, up to the maximum required contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43, 12693.53 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment filed 12–14–98 as an emergency; operative 12–14–98 (Register 98, No. 51). A Certificate of Compliance must be transmitted to OAL by 4–13–99 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 12–14–98 order transmitted to OAL 3–25–99 and filed 5–6–99 (Register 99, No. 19).
5. Repealer of subsections (a)(3)–(a)(3)(B) filed 8–5–99 as an emergency; operative 8–5–99 (Register 99, No. 32). A Certificate of Compliance must be transmitted to OAL by 12–3–99 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5–26–99 order, including further amendment of subsection (c), transmitted to OAL 9–17–99 and filed 10–28–99 (Register 99, No. 44).
7. Certificate of Compliance as to 8–5–99 order transmitted to OAL 11–2–99 and filed 12–1–99 (Register 99, No. 49).
8. Amendment of subsections (a)(1)B. and (a)(2)B. filed 6–20–2000 as an emergency; operative 6–20–2000 (Register 2000, No. 25). A Certificate of Compliance must be transmitted to OAL by 10–18–2000 or emergency language will be repealed by operation of law on the following day.
9. New subsection (d) filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
10. Certificate of Compliance as to 6–20–2000 order transmitted to OAL 10–12–2000; disapproval and reinstatement of text as it existed prior to emergency amendment pursuant to Government Code section 11349.6(d) filed 11–27–2000 (Register 2000, No. 48).
11. Amendment of subsections (a)(1)B. and (a)(2)B. filed 11–28–2000 as an emergency; operative 11–28–2000 (Register 2000, No. 48). A Certificate of Compliance must be transmitted to OAL by 3–28–2001 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 11–28–2000 order transmitted to OAL 1–31–2001 and filed 2–20–2001 (Register 2001, No. 8).
13. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
15. Amendment of subsections (a)(1)(B) and (a)(2)(B) and new subsection (h) filed 7–1–2004 as an emergency; operative 7–1–2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12–28–2004 or emergency language will be repealed by operation of law on the following day.
16. Certificate of Compliance as to 7–1–2004 order transmitted to OAL 11–24–2004 and filed 1–7–2005 (Register 2005, No. 1).
17. Amendment of subsection (e) filed 6–30–2005 as an emergency; operative 6–30–2005 (Register 2005, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–28–2005 or emergency language will be repealed by operation of law on the following day.
18. Amendment of subsection (a)(1)(B), new subsection (a)(1)(C), amendment of subsection (a)(2)(B) and new subsection (a)(2)(C) filed 6–30–2005 as an emergency; operative 6–30–2005 (Register 2005, No. 26). Pursuant to Insurance Code section 12693.43(h), a Certificate of Compliance must be transmitted to OAL by 12–27–2005 or emergency language will be repealed by operation of law on the following day.
19. Certificate of Compliance as to 6–30–2005 order transmitted to OAL 10–5–2005 and filed 11–16–2005 (Register 2005, No. 46).

§ 2699.6811. Notification of Family Contributions Changes.

The program shall notify applicants in writing of change in family child contributions and/or family parent contributions.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2–20–98 as an emergency; operative 2–20–98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6–22–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–20–98 order transmitted to OAL 6–5–98 and filed 7–15–98 (Register 98, No. 29).
3. Amendment of section heading, section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).

§ 2699.6813. Family Contribution Payment for the Program.

Family contribution payment procedures for applicants shall be as follows unless the applicant or person for whom application is being made is an American Indian or Alaska Native and submits acceptable documentation as described in Subsection 2699.6600(c)(1)(GG), or unless the applicant has a family contribution sponsor:

(a) The family child contributions and family parent contributions will be applied for one (1) month or four (4) months, as applicable, starting with the first day of the first full month of coverage. If the applicant or person for whom application is being made is an American Indian or Alaska Native, the family contributions shall not be assessed until the first day of the first full month following the end of the second month of enrollment during which the applicant has not provided acceptable documentation as described in Subsection 2699.6600(c)(1)(GG).

(b) Applicants shall submit their subsequent family contributions to the program so that they are received no later than the monthly due date set by the program.

(c) The program shall apply monies paid first to the family child contributions due, then to the family parent contributions due. Remaining monies shall be applied first to the family child contribution up to the level necessary to earn a free month of coverage, then to the family parent contribution up to the level necessary to earn a free month of coverage, except as provided under Subsection 2699.6605(b)(1).

(d) Applicants who want to receive the one month family contribution discount pursuant to Subsection 2699.6809(c) and (d) must submit their family child contributions, if applicable, and/or family parent contributions, if applicable, at the same time and for the same three (3) month period so that they are received no later than the due date set by the program for the first of the three (3) months.

(e) For each month any family contributions are due, the program shall notify the applicant of the amount of the family contributions due to the program, the due date, and the subscribers for whom the family contributions are being paid. This notification shall be made at least fifteen (15) calendar days in advance of the family contributions due date.

(f) The applicant's obligation to submit the family contributions is not contingent upon receipt of the notice specified in subdivision (d) above. If the applicant does not receive the notice specified in subdivision (d)

above, the applicant shall call the program to determine the amount of the family contributions and shall submit a payment of that amount.

(g) Applicants shall make family contributions in one or more of the following ways: personal check, cashiers check, money order, credit card, debit card, electronic fund transfer, or in cash at designated locations. If a family contribution is paid by a personal check that has been returned for non-sufficient funds, the Program may specify the form of payment that it will accept for the overdue family contribution.

(h) If a subscriber is disenrolled pursuant to Subsection 2699.6611(a), the applicant will be refunded the unused portion of the family contributions, except as provided in Section 2699.6815(e) and Section 2699.6819(c).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2-20-98 as an emergency; operative 2-20-98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-22-98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-20-98 order transmitted to OAL 6-5-98 and filed 7-15-98 (Register 98, No. 29).
3. Amendment of first paragraph filed 3-21-2000 as an emergency; operative 3-21-2000 (Register 2000, No. 12). A Certificate of Compliance must be transmitted to OAL by 7-19-2000 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3-21-2000 order transmitted to OAL 6-23-2000 and filed 7-17-2000 (Register 2000, No. 29).
5. Amendment of first paragraph and subsection (a) filed 9-5-2000; operative 9-5-2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
6. Amendment of section and NOTE filed 4-29-2002 as an emergency; operative 4-29-2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10-28-2002 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 4-29-2002 order, including amendment of subsection (c), transmitted to OAL 10-28-2002 and filed 12-12-2002 (Register 2002, No. 50).
8. Amendment of first paragraph and subsection (a) filed 7-31-2003 as an emergency; operative 7-31-2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-27-2004 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 7-31-2003 order transmitted to OAL 11-17-2003 and filed 12-30-2003 (Register 2004, No. 1).
10. Amendment of first paragraph and subsection (a) filed 7-1-2004 as an emergency; operative 7-1-2004 (Register 2004, No. 27). Pursuant to Section 80, A.B. 1762 (Chapter 230, Stats. 2003) a Certificate of Compliance must be transmitted to OAL by 12-28-2004 or emergency language will be repealed by operation of law on the following day.
11. Certificate of Compliance as to 7-1-2004 order transmitted to OAL 11-24-2004 and filed 1-7-2005 (Register 2005, No. 1).
12. Amendment of subsection (a) deemed an emergency and exempt from OAL review pursuant to Section 75 of Chapter 74, Statutes of 2006, filed 7-31-2007; operative 7-31-2007 (Register 2007, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-28-2008 or emergency language will be repealed by operation of law on the following day.
13. Certificate of Compliance as to 7-31-2007 order transmitted to OAL 1-28-2008 and filed 3-12-2008 (Register 2008, No. 11).

§ 2699.6815. Overdue Payments; Disenrollment.

(a) Applicants whose family child or parent contributions are not paid in full by the due date shall be considered to be overdue.

(b) The program shall notify applicants of the overdue family child and/or parent contributions and the potential for disenrollment from the program within fifteen (15) calendar days following the due date.

(c) No less than thirty (30) calendar days prior to the date of potential disenrollment pursuant to (e) and (f) below, the program shall provide notice to the applicant of the potential disenrollment as specified in Subsection 2699.6611(b).

(d) If the amount of family contributions paid by an applicant is not adequate to cover the combined amount of the family child contributions and family parent contributions, the program will first apply the monies paid toward the family child contributions with any remainder applied toward the family parent contributions.

(e) If family parent contributions are not paid for two (2) consecutive calendar months, the subscriber parents covered by the family contribution shall be disenrolled pursuant to Section 2699.6611. Termination of coverage shall be at the end of the second consecutive month for which the family parent contributions were not paid in full. Any credit remaining from the family parent contributions after a subscriber parent's disenrollment from the program will be applied toward any family child contributions applicable to a subscriber child who is enrolled in the program and to whom the subscriber parent is linked.

(f) If family child contributions are not paid for two (2) consecutive calendar months, all subscriber children covered by the family child contributions shall be disenrolled pursuant to Section 2699.6611. Termination of coverage shall be at the end of the second consecutive month for which the family child contributions were not paid in full.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.45 and 12693.755, Insurance Code.

HISTORY

1. New section filed 2-20-98 as an emergency; operative 2-20-98 (Register 98, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-22-98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-20-98 order transmitted to OAL 6-5-98 and filed 7-15-98 (Register 98, No. 29).
3. Amendment of section and NOTE filed 4-29-2002 as an emergency; operative 4-29-2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10-28-2002 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4-29-2002 order transmitted to OAL 10-28-2002 and filed 12-12-2002 (Register 2002, No. 50).
5. Amendment of subsections (e)-(f) filed 7-31-2003 as an emergency; operative 7-31-2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1-27-2004 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 7-31-2003 order transmitted to OAL 11-17-2003 and filed 12-30-2003 (Register 2004, No. 1).

§ 2699.6817. Family Contribution Sponsor Registration.

(a) Family contribution sponsors must register with the Board.

(b) To be registered, a family contribution sponsor must:

(1) complete and return a Healthy Families Program Family Contribution Sponsor Registration form (HFP-Sponsor 1 (new 7/00)), which is hereby incorporated by this reference, and

(2) receive a sponsor identification number from the Board.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 9-5-2000; operative 9-5-2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).

§ 2699.6819. Family Contribution Sponsor Payments.

(a) For each applicant being sponsored, the family contribution sponsor shall submit payment for twelve (12) months of family child contributions if the family contribution sponsor is sponsoring a subscriber child, and twelve (12) months of family parent contributions if the family contribution sponsor is sponsoring a subscriber parent. The family contribution sponsor shall also submit the completed and signed Healthy Families Program Family Contribution Sponsorship Payment form (HFP-Sponsor 2 (new 7/00)) which is hereby incorporated by this reference.

(b) The payment for twelve (12) months of family child contributions shall be the family child contributions amount determined pursuant to Subsection 2699.6809(e) multiplied by 12. The payment for twelve (12) months of family parent contributions shall be the family parent contributions amount determined pursuant to Subsection 2699.6809(f) multiplied by 12.

(c) Payment of the amount specified in subsection (b) above shall be considered payment in full for the applicant for the twelve (12) consecutive months in the Program or, as of the parental coverage start date, for any twelve consecutive months in the program. No premium adjustments will be made for any reason during the period.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

HISTORY

1. New section filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).
2. Amendment of section and NOTE filed 4–29–2002 as an emergency; operative 4–29–2002 (Register 2002, No. 18). Pursuant to Chapter 946, Statutes of 2000, section 2, a Certificate of Compliance must be transmitted to OAL by 10–28–2002 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4–29–2002 order transmitted to OAL 10–28–2002 and filed 12–12–2002 (Register 2002, No. 50).
4. Amendment of subsection (c) filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).

§ 2699.6821. Eligibility as a Family Contribution Sponsor.

(a) The following persons or entities are not eligible to be family Contribution sponsor:

(1) a person that is a health care, dental care or vision care provider that participates in the Healthy Families Program or an organization composed primarily of or controlled by such persons,

(2) an entity, including governmental, school, non–profit and charitable organizations, that is, or that operates, an institution or facility that is a health care, dental care or vision care provider that participates in the Healthy Families Program.

(3) a participating plan.

(4) any person or entity acting on behalf of or representing a person or entity identified in (1) through (3) above.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).

§ 2699.6823. Family Contribution Sponsor Certification Requirement.

(a) Any person or entity seeking to provide payment as a family contribution sponsor must certify both of the following:

(1) that the person or entity is not ineligible to be a family contribution sponsor under Section 2699.6821, and

(2) that the person or entity acknowledges that the Board has taken no position as to whether payment of premiums as a family contribution sponsor by any person or entity would be in violation of federal fraud and abuse laws.

(b) The certification shall be made on the Healthy Family Program Family Contribution Registration form (HFP–Sponsor 1 (new 7/00)).

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).

§ 2699.6825. Family Contribution Sponsor Disqualification.

The Board may refuse to allow a registered family contribution sponsor to sponsor any additional applicants if the Board determines that the sponsor has violated or encouraged an applicant to violate program rules. The sponsor will be notified in writing of such a determination. The sponsor may appeal the determination by filing a written request for review by the Executive Director.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code.

HISTORY

1. New section filed 9–5–2000; operative 9–5–2000 pursuant to Government Code 11343.4(d) (Register 2000, No. 36).

§ 2699.6827. Payment of State Supported Services.

State Supported Services shall be paid for by State dollars only. No Federal dollars provided to the State pursuant to title XXI of the Social Security Act shall be used.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.21, Insurance Code; and 42 CFR Section 457.475.

HISTORY

1. New section filed 7–31–2003 as an emergency; operative 7–31–2003 (Register 2003, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–27–2004 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 7–31–2003 order transmitted to OAL 11–17–2003 and filed 12–30–2003 (Register 2004, No. 1).

Article 5. Child Health and Disability Prevention Program Payments

§ 2699.6900. Child Health and Disability Prevention Program Providers.

(a) For purposes of meeting the requirements of Insurance Code Section 12693.41, regarding reimbursement of providers who participate in the Child Health and Disability Prevention (CHDP) Program, providers are defined as:

(1) CHDP health assessment providers, are those individuals and entities described in Title 17, California Code of Regulations, Section 6860 and 6862, who provide well–child health assessment and immunizations.

(2) CHDP initial treatment providers, are those providers that participate in the Medi–Cal and Denti–Cal program and provide initial treatment of a condition that has been identified during the well–child health assessment.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.41, Insurance Code.

HISTORY

1. New article 5 (sections 2699.6900–2699.6905) and section filed 8–28–98 as an emergency; operative 8–28–98 (Register 98, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–28–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–28–98 order transmitted to OAL 12–18–98 and filed 2–2–99 (Register 99, No. 6).

§ 2699.6903. Reimbursable Services.

(a) For purposes of meeting the requirements of Insurance Code Section 12693.41 relating to the Healthy Families Program reimbursements, a "CHDP well–child health assessment" is as defined in Title 17, California Code of Regulations, Section 6800 and shall include those services specified in Title 17, California Code of Regulations, Section 6846.

(b) For purposes of meeting the requirements of Insurance Code Section 12693.41 relating to the Healthy Families Program reimbursement, "initial treatment" means those services provided in the 90 days prior to a person's effective date of coverage by a Healthy Families Program participating health plan that are necessary for diagnosis and treatment of a condition identified during the "CHDP well–child health assessment". These services may include, but are not limited to:

(1) Outpatient physician services including referral to outpatient specialty care, laboratory services, x–ray services, prescription drugs and those medical supplies and equipment necessary to administer prescribed medication.

(2) Inpatient hospital care.

(3) Emergency dental services that are medically necessary for the relief of pain and treatment of infection.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.41, Insurance Code.

HISTORY

1. New section filed 8–28–98 as an emergency; operative 8–28–98 (Register 98, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–28–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–28–98 order, including amendment of subsection (b)(3), transmitted to OAL 12–18–98 and filed 2–2–99 (Register 99, No. 6).
3. Amendment of subsection (b) filed 1–10–2000 as an emergency; operative 1–10–2000 (Register 2000, No. 2). A Certificate of Compliance must be transmitted to OAL by 5–9–2000 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 1–10–2000 order transmitted to OAL 5–5–2000 and filed 6–16–2000 (Register 2000, No. 24).

§ 2699.6905. Reimbursement Rates.

(a) For the purposes of meeting the requirement of Insurance Code section 12693.41 relating to the Healthy Families Program, well–child health assessments and immunizations provided to persons who subsequently enroll in the Healthy Families Program pursuant to Article 2, shall be reimbursed at the rates specified in Title 17, California Code of Regulations, Section 6868. CHDP health assessment providers shall submit claims for these services in accordance with Title 17, California Code of regulations, Section 6866 to the State Department of Health Services (DHS).

(b) For the purposes of meeting the requirement of Insurance Code Sections 12693.41 relating to the Healthy Families Program, providers shall be reimbursed for initial treatment provided to persons who subsequently enroll in the Healthy Families Program pursuant to Article 2, at the Medi–Cal rate, as specified in Title 22, California Code of Regulations, Sections 51501 et. seq. A county that reimburses a provider at a county–specific rate that is less than the Medi–Cal rate for treatment services for a condition identified in a CHDP health assessment will be reimbursed by the Healthy Families Program at the rate the county reimburses the treatment provider. Providers shall submit claims to the DHS for these services on the Health Insurance Claim Form (HCFA 1500, revised version 12/90), accompanied by a legible copy of any DHS approved version of the Confidential Screening/Billing Report (PM 160).

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Section 12693.41, Insurance Code.

HISTORY

1. New section filed 8–28–98 as an emergency; operative 8–28–98 (Register 98, No. 35). A Certificate of Compliance must be transmitted to OAL by 12–28–98 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 8–28–98 order, including amendment of subsection (b), transmitted to OAL 12–18–98 and filed 2–2–99 (Register 99, No. 6).

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 6. Real Estate Commissioner

Vol. 14

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Article 36. Conflict of Interest Code of the Department of Real Estate 822.13

Chapter 6. Real Estate Commissioner

(Originally Printed 3–22–45)

Article 1. General Provisions

§ 2700. Offices.

NOTE: Authority cited: Sections 10080, 10170.4, 10226, 10249.2, 10312, 11001, 11011.8 and 11018.9, Business and Professions Code. Reference: Section 10077, Business and Professions Code.

HISTORY

1. Amendment filed 11–30–77; effective thirtieth day thereafter (Register 77, No. 49). For prior history, see Register 77, No. 7.
2. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2705. General Definitions and Short Form References.

Unless otherwise expressly indicated or compelled by the context in which used, words, phrases and short form references appearing in this Chapter shall have meanings as ascribed herein.

(a) "Advertising." Any written or printed communication, or oral communication made in accordance with a text or outline that has been reduced to written form, which is published for the purpose of inducing persons to purchase or use a product or service.

(b) "Applicant." A person applying to the Department of Real Estate for a license, permit, public report or other entitlement.

(c) "Code." The Business and Professions Code.

(d) "Commissioner." The Real Estate Commissioner of the State of California.

(e) "Department." The Department of Real Estate of the State of California.

(f) "Examination." Any examination to qualify for any license issued under authority of the Real Estate Law.

(g) "License." Any license issued under authority of the Real Estate Law.

(h) "Permit." Any authorization or entitlement issued by the commissioner to engage in a transaction or course of conduct for which a permit is required under the Real Estate Law or Subdivided Lands Law.

(i) "Public Report." The report issued by the commissioner under authority of Section 11018 of the Code.

(j) "Real Estate Law." Part 1 of Division 4 of the Code.

(k) "Subdivision Interests." Lots, parcels, units, undivided interest shares, time–share estates or time–share uses subject to regulation under the provisions of Chapter 1, Part 2, Division 4 of the Code.

(*l*) "Subdivision Law" or "Subdivided Lands Law." Chapter 1 of Part 2 of Division 4 of the Code.

(m) "Common Interests." Property owned or controlled by, and/or services furnished to, owners, lessees or persons having the exclusive right to the use of subdivision interests, by an association comprising the separate owners of said interests in those subdivisions enumerated in Section 11004.5 of the Code.

NOTE: Authority cited: Section 10080, 11001, Business and Professions Code. Reference: Section 11000 (Ch. 601, Stats. 1980), Business and Professions Code.

HISTORY

1. Amendment filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50). For prior history see Register 68, No. 39.
2. Repealer and new section filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49).
3. New subsection (m) filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
4. Amendment of subsection (k); effective thirtieth day thereafter (Register 80, No. 49).

§ 2708. Permit Reform Act Definitions.

NOTE: Authority cited: Section 10080, Business and Professions Code; Section 15376, Government Code. Reference: Section 15376, Government Code.

HISTORY

1. New section filed 5–26–92; operative 6–25–92 (Register 92, No. 22).
2. Repealer filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2709. Permit Processing Times.

NOTE: Authority cited: Section 10080, Business and Professions Code; Section 15376, Government Code. Reference: Section 15376, Government Code.

HISTORY

1. New section filed 5–26–92; operative 6–25–92 (Register 92, No. 22).
2. Amendment filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
3. Amendment filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
4. Repealer filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

Article 3. License Applications, Fees and Changes

§ 2710. Applications and Notices of Change of Status.

(a) A person shall apply for an original license under the provisions of the Real Estate Law on the form of application prescribed by the Department. The applicant shall complete and sign the application form and submit it and the fee for the license in question to an office of the Department.

(b) A licensee applying for renewal of a real estate license shall comply with the provisions of subdivision (a) and with the following provisions:

(1) The application shall be submitted to the Department not more than 90 days before the expiration of the license to be renewed.

(2) The applicant shall submit on forms prescribed by the Department, information to establish that the applicant has satisfied the continuing education prerequisites for license renewal in Article 2.5 of Chapter 3 of the Real Estate Law.

(c) Notice of changes in license information or status required to be submitted to the Department under provisions of the Real Estate Law and regulations of the Commissioner shall be given on forms prescribed by the Department not later than five days after the effective date of the change unless otherwise provided in the applicable statute or regulation.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10150, 10151, 10156.2, 10161.8, 10167.3 and 10515, Business and Professions Code.

HISTORY

1. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Amendment filed 12–30–70; effective thirtieth day thereafter (Register 71, No. 1).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment of subsection (b)(1) filed 10–26–99; operative 11–25–99 (Register 99, No. 44).

§ 2711. Fingerprints.

HISTORY

1. Amendment filed 3–1–68; effective thirtieth day thereafter (Register 68, No. 9).
2. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
3. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
4. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2712. Fingerprints.

An original applicant for a real estate license may submit his or her fingerprints (a) with the application to take the license examination; (b) at anytime after submitting the application to take the license examination; or (c) with the application for a real estate license.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10152, Business and Professions Code.

HISTORY

1. New section filed 3–17–2005; operative 4–16–2005 (Register 2005, No. 11). For prior history, see Register 83, No. 30.

§ 2713. Electronic Signature.

When a signature is required in an electronic transaction through the Department of Real Estate Web site the person seeking to submit the transaction shall make the certification(s) in the appropriate fields and in the manner specified by the Department on the Department's Web site. Submission of a transaction in this manner through the Department's

Web site shall constitute irrefutable evidence of legal signature by any individual submitting such transaction to the Department.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10150 and 10151, Business and Professions Code.

HISTORY

1. New section filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9). For prior history, see Register 83, No. 30.

§ 2714. Successive Original Licenses.

HISTORY

1. New section filed 2–19–57; effective thirtieth day thereafter (Register 57, No. 4).
2. Amendment filed 2–25–60; effective thirtieth day thereafter (Register 60, No. 4).
3. Repealer filed 9–17–65; designated effective 1–2–66 (Register 65, No. 17).

§ 2715. Business and Residence Addresses of Licensees.

Every broker, except a broker acting in the capacity of a salesperson to another broker under written agreement, shall maintain on file with the commissioner the address of his principal place of business for brokerage activities, the address of each branch business office and his current mailing address, if different from the business address.

Every broker who is acting in the capacity of a salesperson to another broker under written agreement shall maintain on file with the commissioner the address of the business location where he expects to conduct most of the activities for which a license is required and his current mailing address.

A real estate salesperson shall maintain on file with the commissioner his current mailing address, and when applicable, the address of the principal business office of the broker to whom the salesperson is at the time licensed.

Whenever there is a change in the location or address of the principal place of business or of a branch office of a broker, he shall notify the commissioner thereof not later than the next business day following the change.

This section shall apply to the holder of a real estate license who fails to renew it prior to the period for which it was issued and who is otherwise qualified for such license as set forth in Section 10201 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10162, 10163 and 10201, Business and Professions Code.

HISTORY

1. New section filed 7–16–64; effective thirtieth day thereafter (Register 64, No. 15).
2. Repealer and new section filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
3. Repealer and new section filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49).
4. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
5. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
6. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
7. Amendment of section and NOTE filed 4–1–93; operative 5–1–93 (Register 93, No. 14).
8. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
9. Amendment of second paragraph filed 10–26–99; operative 11–25–99 (Register 99, No. 44).

§ 2715.5. Additional Information — Examination and License Applications.

The Commissioner may require a person, who has filed a salesperson exam/license application or a broker exam/license application, to file updated information concerning the applicant's mailing address, main office address, broker affiliation of record, prior criminal history, or professional license disciplinary history.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10150, 10151 and 10152, Business and Professions Code.

HISTORY

1. New section filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2716. License Fees.

NOTE: Authority cited: Sections 10080 and 10226, Business and Professions Code. Reference: Sections 10153.4, 10201, 10209.5, 10210, 10214.5 and 10215, Business and Professions Code.

HISTORY

1. New section filed 12–10–71; designated effective 4–1–72 (Register 71, No. 50).
2. Amendment and new subsection (3) filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49).
3. Amendment filed 7–9–80; designated effective thirtieth day thereafter (Register 80, No. 28).
4. Amendment filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
5. Repealer of section, new section and amendment of NOTE filed 11–1–96; operative 1–1–97 (Register 96, No. 44).
6. Amendment of subsection (4), new subsections (5) and (6), and subsection renumbering filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
7. Amendment of subsections (1)–(6) filed 6–18–98; operative 8–1–98. Submitted to OAL for printing only pursuant to Business and Professions Code section 10226 (Register 98, No. 26).
8. Amendment of subsections (1)–(6) filed 6–1–99; amended and refiled 7–14–99; operative 8–1–99. Submitted to OAL for printing only pursuant to Business and Professions Code section 10226 (Register 99, No. 29).
9. Amendment of subsections (1)–(6) filed 5–16–2001; operative 6–15–2001 (Register 2001, No. 20).
10. Repealer filed 5–1–2007; operative 5–31–2007 (Register 2007, No. 18).

§ 2716.1. License Fees.

(1) The license fee for the real estate broker license under Section 10210 of the Code shall be $165.

(2) The license fee for the real estate salesperson license under Section 10215 of the Code shall be $120.

(3) The salesperson license fee, under Section 10215 of the Code, for an applicant qualifying pursuant to Section 10153.4 of the Code who has not satisfied all of the educational requirements prior to issuance of the license, shall be $145.

(4) The late license renewal fee under Section 10201 of the Code shall be $248 for a real estate broker or restricted real estate broker license and $180 for a real estate salesperson or restricted real estate salesperson license.

(5) The license fee for the restricted real estate broker license under Section 10209.5 of the Code shall be $165.

(6) The license fee for the restricted real estate salesperson license under Section 10214.5 of the Code shall be $120.

(7) The fees for all licenses or examinations, except those specified in this regulation or as otherwise specifically provided for in the regulations, shall be as follows: broker examination or reexamination: $50; first reschedule of broker examination: $15; subsequent reschedules: $25; salesperson examination or reexamination: $25; first reschedule of salesperson examination: $10; subsequent reschedules: $25.

NOTE: Authority cited: Sections 10080 and 10226, Business and Professions Code. Reference: Sections 10153.4, 10201, 10209.5, 10210, 10214.5 and 10215, Business and Professions Code.

HISTORY

1. New section filed 7–15–2003; operative 8–31–2003 (Register 2003, No. 29).
2. Repealer of subsections (a) and (b) filed 5–1–2007; operative 5–31–2007 (Register 2007, No. 18).

§ 2716.5. Special Fee.

A licensee or applicant who is named on a certified list or supplemental list pursuant to Section 17520 of the Family Code shall pay a special fee in the amount of ninety–five dollars ($95.00) for each time his or her name is placed on such list. If the licensee or applicant fails to pay such fee, the commissioner shall refuse to issue a license or temporary license or to reinstate a suspended license.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 17520, Family Code.

HISTORY

1. New section filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
2. Amendment of section and NOTE filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2717. Allocation of Fees to Education and Research Account.

Pursuant to Section 10450.6 of the Code, no portion of the amount of the license fee collected under Part 1 of Division 4 of the Code shall be credited to the Education and Research Account.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10450.6, Business and Professions Code.

HISTORY

1. New section filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
2. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2718. Legal Presence Requirements.

(a) All eligibility requirements contained herein shall be applied without regard to the race, creed, color, gender, religion, or national origin of the individual applying for a benefit.

(b) Pursuant to Section 411 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1995, (Pub. L. No. 104–193 (PRWORA)), (8 U.S.C. § 1621), and notwithstanding any other provision of law, aliens who are not qualified aliens, nonimmigrant aliens under the Immigration and Nationality Act (INA) (8 U.S.C. § 1101 et seq.), or aliens paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)), for less than one year, are not eligible to receive benefits as defined in this Section and as set forth in Sections 10000 and following of the Code.

(c) For purposes of this Section, a benefit is an original real estate broker license, real estate broker officer license, real estate salesperson license, prepaid rental listing service license, mineral, oil, and gas broker license and a renewal of such licenses which has not been previously qualified pursuant to this Section. A qualified alien without permanent status shall provide proof of qualification for each renewal of a license. A benefit does not include a payment from the Real Estate Recovery Account.

(d) A qualified alien is an alien who, at the time he or she applies for, receives, or attempts to receive a benefit, is, under Section 431(b) of the PRWRORA (8 U.S.C. § 1641(b)), any of the following:

(1) An alien lawfully admitted for permanent residence under the INA (8 U.S.C. § 1101 et seq.).

(2) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. § 1158).

(3) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. § 1157).

(4) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)) for a period of at least one year.

(5) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. § 1253(h)) (as in effect immediately before the effective date of Section 307 of division C of Public Law 104–208) or Section 241(b)(3) of such Act (8 U.S.C. § 1251(b)(3)) (as amended by Section 305(a) of division C of Public Law 104–208).

(6) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980. (8 U.S.C. § 1153(a)(7)) (See editorial note under 8 U.S.C. § 1101, "Effective Date of 1980 Amendment.")

(7) An alien who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (8 U.S.C. § 1522 note)).

(8) An alien who meets all of the conditions of subparagraphs (A), (B), (C), and (D) below:

(A) The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Department. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien to lose his or her job or to earn less or to require the alien to leave his or her job for safety reasons.

5. The benefits are needed because the alien requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

(C) The alien has a petition that has been approved or has a petition pending which sets forth a prima facie case for:

1. status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. § 1154(a)(1)(A)(ii), (iii) or (iv),

2. classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. § 1154(a)(1)(B)(ii) or (iii).

3. suspension of deportation and adjustment of status pursuant to section 244(a)(3) of the INA (as in effect prior to April 1, 1997) [Pub.L. 104–208, sec. 501 (effective Sept. 30, 1996, pursuant to sec. 304), Pub.L. 105–33, sec. 81 (effective pursuant to sec. 5582)] (codified as cancellation of removal under section 240A of such Act" [8 U.S.C. § 1229b] (as in effect prior to April 1, 1997).

4. status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. § 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(I)(B) of the INA (8 U.S.C. § 1154(a)(1)(B)(i)), or

5. cancellation or removal pursuant to Section 240A(b)(2) of the INA (8 U.S.C. § 1229b(b)(2)),

(D) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(9) An alien who meets all of the conditions of subparagraphs (A), (B), (C), (D) and (E) below:

(A) The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or sub-

jected to extreme cruelty" includes but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) The alien did not actively participate in such battery or cruelty.

(C) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Department. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien's child to become self-sufficient following separation from the abuser.

2. The benefits are needed to enable the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien's child from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's child's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien's child to lose his or her job or to earn less or to require the alien's child to leave his or her job for safety reasons.

5. The benefits are needed because the alien's child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's child's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien's child and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien's child had when living with the abuser.

(D) The alien meets the requirements of subsection (d)(8)(C) above.

(E) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(e) For purposes of this section, "nonimmigrant" is defined the same as in Section 101(a)(15) of the INA (8 U.S.C. § 1101(a)(15)).

(f) A person applying for a benefit for which the applicant is otherwise qualified, must do all of the following:

(1) Declare himself or herself to be a citizen of the United States or a qualified alien under subsection (c), a nonimmigrant alien under subsection (d), or an alien paroled into the United States for less than one year under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)). The applicant shall declare that status by completing and signing the "State Public Benefits Statement" (DRE Form 205).

(2) Present documents of a type acceptable to the Immigration and Naturalization Services (INS) and as set forth in List A or List B of DRE Form 205 and which serve as reasonable evidence of the applicant's declared status.

(3) Where the documents presented do not on their face appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the documents shall be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The Department shall request verification from the INS by filing INS Form G–845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant shall be referred to the local INS office to obtain documentation.

(g) Where authorized by the INS, the information presented by an alien as reasonable evidence of the alien's declared immigration status must be submitted to the INS for verification through the Systematic Alien Verification for Entitlements (SAVE) system procedures as follows:

(1) Unless the primary SAVE system is unavailable for use, the primary SAVE system verification must be used to access the biographical/immigration status computer record contained in the Alien Status Verification Index maintained by the INS. Subject to subparagraph (2), this procedure must be used to verify the status of all aliens who claim to be qualified aliens and who present an INS–issued document that contains an alien registration or alien admission number.

(2) In any of the following cases, the secondary SAVE system verification procedure must be used to forward to INS copies of INS documents evidencing an alien's status as a qualified alien, as a nonimmigrant alien under the INA, or as an alien paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)), for less than one year:

(A) The primary SAVE system is unavailable for verification.

(B) A primary check of the Alien Status Verification Index instructs the Department to "institute secondary verification."

(C) The document presented indicates immigration status but does not include an alien registration or alien admission number.

(D) The Alien Status Verification Index record includes the alien registration or admission number on the document presented by the alien but does not match other information contained in the document.

(E) The document is suspected to be counterfeit or to have been altered.

(F) The document includes an alien registration number in the A60 000 000 (not yet issued) or A80 000 000 (illegal border crossing) series.

(G) The document is a fee receipt from INS for replacement of a lost, stolen, or unreadable INS document and the applicant has failed to submit his or her registration or alien admission number.

(H) The document is one of the following: an INS Form I–181b notification letter issued in connection with an INS Form I–181 Memorandum of Creation of Record of Permanent Residence, an Arrival–Departure Record (INS Form I–94) or a foreign passport stamped "PROCESSED FOR I–551, TEMPORARY EVIDENCE OF LAWFUL PERMANENT RESIDENCE" that INS issued more than one year before the date of application for a benefit.

(I) If the secondary SAVE system is available and is used to verify status, provided that the alien has completed and signed Form 205 under penalty of perjury, and has presented documents of a type acceptable to

the Immigration and Naturalization Services (INS) and as set forth in List B of DRE Form 205 and which serve as reasonable evidence of the applicant's declared status, eligibility for the benefit shall not be delayed, denied, reduced or terminated while the status of the alien is verified. If the Department determines that any documents have been falsified or that the applicant is not entitled to the benefit, the Department shall suspend such benefit.

(h) The applicant may present documents described in subparagraphs (f)(1), (2) and (3) above which serve as reasonable evidence of the applicant's declared status prior to applying for a benefit or prior to applying for the renewal of a benefit.

(i) If the primary and secondary SAVE systems are unavailable for verification for purposes of establishing an alien's eligibility for a benefit for which the applicant is otherwise qualified, all of the following must be met:

(1) The applicant who is not a citizen of the United States must declare himself or herself to be a qualified alien under subsection (d), a nonimmigrant alien under subsection (e), or an alien paroled into the United States for less than one year under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)). The alien shall declare that status through use of the DRE Form 205.

(2) The alien must present documents or temporary documents issued by the INS which serve as reasonable evidence of the applicant's declared status. A fee receipt from the INS for replacement of a lost, stolen, or unreadable INS document and an alien registration or alien admission number from INS are temporary documents considered reasonable evidence of the alien's declared status.

(3) Upon receipt of the documents described in subparagraphs (1) and (2) above, and provided that the alien has completed and signed Form 205 under penalty of perjury, eligibility for the benefit shall not be delayed, denied, reduced or terminated while the status of the alien is verified. If the Department determines that any such documents have been falsified or that the applicant is not entitled to the benefit, the Department shall suspend such benefit.

(j) Where the documents presented to verify status do not on their face appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the documents shall be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The Department shall request verification from the INS by filing INS Form G-845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant shall be referred to the local INS office to obtain documentation.

(k) If the INS advises that the applicant has citizenship status or immigration status which makes him or her a qualified alien under the PRWORA, the INS verification shall be accepted. If the INS advises that it cannot verify that the applicant has citizenship status or an immigration status that makes him or her a qualified alien, benefits shall be denied and the applicant notified pursuant to Section 10100 of the Code of his or her rights to appeal the denial of benefits.

(*l*) Provided that the alien has completed and signed Form 205 under penalty of perjury and presented documents issued by the INS which serve as reasonable evidence of the applicant's declared status, eligibility for the benefit shall not be delayed, denied, reduced or terminated while the status of the alien is verified.

(m) Pursuant to Section 434 of the PRWORA (8 U.S.C. § 1644), where the Department reasonably believes that an alien is unlawfully in the State based on the failure of the alien to provide reasonable evidence of the alien's declared status, after an opportunity to do so, said alien shall be reported to the INS.

(n)(1) If an applicant for the timely renewal of a benefit has submitted, in good faith, evidence of eligibility pursuant to this section which he had reason to believe would qualify him for renewal of a benefit, but the Department finds that the evidence submitted may not qualify, the Department may, nonetheless, extend the benefit for 90 days in order to allow the applicant to submit additional evidence of eligibility, which satisfies the requirements of this section.

(2) Upon written request, which establishes good cause, from an applicant who has received an extension pursuant to subparagraph (*l*)(1), and upon proof that the applicant has complied with the continuing education requirements of Article 2.5 of Chapter 3 of the Code, the Department may, grant an additional extension not to exceed 60 days in order to allow the applicant to submit additional evidence of eligibility, which satisfies the requirements of this section.

(3) When the benefit is issued during or at the end of the extension provided for in this section it shall expire four years from the date otherwise applicable as if no extension had been granted.

(o) Any denial of a benefit pursuant to this Section shall be subject to Section 10100 of the Code.

(p) This Section does not apply to the issuance of a professional license to, or the renewal of a professional license by, a foreign national not physically present in the United States.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: 8 U.S.C. Sections 1621, 1641 and 1642.

HISTORY

1. New section filed 3–12–98; operative 8–1–98 (Register 98, No. 11).
2. Amendment of section heading and new subsection (p) filed 10–26–99; operative 11–25–99 (Register 99, No. 44).
3. Amendment of subsections (c), (g)(2)(I), (i)(3) and (*l*) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).

Article 4. Brokers

§ 2720. Minimum Age.

A real estate broker license shall not be issued to a person who has not attained the age of 18 years.

HISTORY

1. Amendment filed 12–27–72; effective thirtieth day thereafter (Register 72, No. 53).

§ 2721. Character References.

HISTORY

1. Repealer filed 10–16–58; effective thirtieth day thereafter (Register 58, No. 19).

§ 2722. Investigation Period.

HISTORY

1. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Repealer filed 3–1–68; effective thirtieth day thereafter (Register 68, No. 9).

§ 2723. Inactive Broker Must File Address.

HISTORY

1. New section filed 8–17–53; effective thirtieth day thereafter (Register 53, No. 14).
2. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
3. Repealer filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).

§ 2724. Minimum Requirements for Supervision Under Section 10131.01.

A broker may delegate the responsibility and authority to supervise and control the activities of nonlicensed persons acting under Section 10131.01:

(a) To a real estate broker acting in the capacity of a salesperson to the employing broker and who has entered into a written agreement relating thereto with the employing broker.

(b) To a real estate salesperson licensed to the broker if the salesperson has accumulated at least two years full–time experience as a salesperson licensee during the immediately preceding five–year period and has entered into a written agreement with the broker with respect to the delegation of responsibility.

NOTE: Authority cited: Sections 10080 and 10131.01, Business and Professions Code. Reference: Section 10131.01, Business and Professions Code.

HISTORY
1. New section filed 2–19–57; effective thirtieth day thereafter (Register 57, No. 4).
2. Repealer filed 7–12–80; effective thirtieth day thereafter (Register 80, No. 28).
3. New section filed 5–26–92; operative 6–25–92 (Register 92, No. 22).

§ 2725. Broker Supervision.

A broker shall exercise reasonable supervision over the activities of his or her salespersons. Reasonable supervision includes, as appropriate, the establishment of policies, rules, procedures and systems to review, oversee, inspect and manage:

(a) Transactions requiring a real estate license.

(b) Documents which may have a material effect upon the rights or obligations of a party to the transaction.

(c) Filing, storage and maintenance of such documents.

(d) The handling of trust funds.

(e) Advertising of any service for which a license is required.

(f) Familiarizing salespersons with the requirements of federal and state laws relating to the prohibition of discrimination.

(g) Regular and consistent reports of licensed activities of salespersons.

The form and extent of such policies, rules, procedures and systems shall take into consideration the number of salespersons employed and the number and location of branch offices.

A broker shall establish a system for monitoring compliance with such policies, rules, procedures and systems. A broker may use the services of brokers and salespersons to assist in administering the provisions of this section so long as the broker does not relinquish overall responsibility for supervision of the acts of salespersons licensed to the broker.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10177(h), Business and Professions Code.

HISTORY
1. New section filed 11–19–69; designated effective 1–2–70 (Register 69, No. 47).
2. Amendment filed 12–10–71; effective thirtieth day thereafter. (Register 71, No. 50).
3. Amendment filed 12–27–72; effective thirtieth day thereafter (Register 72, No. 53).
4. Repealer and new section filed 11–30–77; effective thirtieth day thereafter (Register 77, No. 49).
5. Editorial correction of HISTORY 2 and 3 (Register 95, No. 13).
6. Amendment of section heading, repealer and new section, and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2726. Broker–Salesman Relationship Agreements.

Every real estate broker shall have a written agreement with each of his salesmen, whether licensed as a salesman or as a broker under a broker–salesman arrangement. The agreement shall be dated and signed by the parties and shall cover material aspects of the relationship between the parties, including supervision of licensed activities, duties and compensation.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10177(h), Business and Professions Code.

HISTORY
1. New section filed 12–10–71; designated effective 4–1–72 (Register 71, No. 50).
2. Amendment of section and new NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2727. Disclosure of Principal Transactions.

NOTE: Authority cited: Sections 10080, 10170.4, 10226, 10149.2, 11001 and 11011.8, Business and Professions Code and Section 21082, Public Resources Code.

HISTORY
1. New section filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49).
2. Amendment filed 11–30–77; effective thirtieth day thereafter (Register 77, No. 49).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2728. Partners Operating from Branch Offices.

A real estate broker who is a member of a partnership operating as a real estate brokerage business under written agreement may conduct business from a branch office of the partnership without acquiring a branch office license in his own name if another broker member of the partnership has a current branch office license at the location in question.

NOTE: Authority cited: Sections 10080, 10226, 11001, 11011.8, Business and Professions Code and Section 21082, Public Resources Code.

HISTORY
1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).

§ 2728.5. Broker/Salesman Operating from Branch Offices.

A real estate broker acting in the capacity of a salesman to another broker under written agreement may perform acts for which a license is required on behalf of the employing broker at any place of business at which the employing broker is currently licensed to perform acts for which a real estate license is required.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code and Section 21082, Public Resources Code.

HISTORY
1. New section filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).

§ 2729. Record Retention.

(a) A real estate broker may use electronic image storage media to retain and store copies of all listings, deposit receipts, canceled checks, trust records and other documents executed by him or her or obtained by him or her in connection with any transaction for which a real estate broker license is required, provided the following requirements are satisfied:

(1) The electronic image storage shall be nonerasable "write once, read many" ("WORM") that does not allow changes to the stored document or record.

(2) The stored document or record is made or preserved as part of and in the regular course of business.

(3) The original record from which the stored document or record was copied was made or prepared by the broker or the broker's employees at or near the time of the act, condition or event reflected in the record.

(4) The custodian of the record is able to identify the stored document or record, the mode of its preparation, and the mode of storing it on the electronic image storage.

(5) The electronic image storage system contains a reliable indexing system that provides ready access to a desired document or record, appropriate quality control of the storage process to ensure the quality of imaged documents or records, and date ordered arrangement of stored documents or records to assure a consistent and logical flow of paperwork to preclude unnecessary search time.

(6) Records copied and stored under this section shall be retained for three years pursuant to Section 10148 of the Code.

(b) A broker will maintain at the broker's office a means of viewing copies of documents or records stored pursuant to this section. A broker shall provide, at the broker's expense, a paper copy of any document or record requested by the Department.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10148, Business and Professions Code.

HISTORY
1. New section filed 10–26–99; operative 11–25–99 (Register 99, No. 44). For prior history, see Register 96, No. 48.
2. Amendment of subsections (a)–(a)(1) and (a)(4)–(5) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).

§ 2729.5. Record Retention—Uniform Electronic Transactions Act.

(a) A real estate broker who obtains documents in connection with any transaction for which a real estate broker license is required when such documents contain an electronic signature pursuant to the Uniform Electronic Transactions Act (Section 1633.1 et seq. of the Civil Code) or the Electronic Signatures in Global and National Commerce Act shall retain a copy of such documents, including the electronic signatures. The broker shall retain a copy of such documents by: 1) Causing a paper copy of the document to be made or 2) By using electronic image storage media pursuant to Section 2729. The broker may retain copies of such documents at a location other than the broker's place of business.

(b) A broker shall maintain at the broker's office a means of viewing copies of documents or records stored pursuant to this section. After no-

tice, such documents or records shall be made available for examination, inspection, and copying by the Commissioner or his or her designated representative during regular business hours. The broker shall provide, at the broker's expense, a paper copy of any document or record requested by the Department.

(c) Nothing in this section shall be construed to permit a broker to avoid compliance with Section 10148 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10148, Business and Professions Code.

HISTORY

1. New section filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).

Article 5. Licenses Under Fictitious Names

§ 2730. Definitions of Fictitious Name.

NOTE: Authority cited for new Article 5 (Sections 2730, 2731, 2732, and 2733); Sections 10080, 10176.2 and 11001, Business and Professions Code.

HISTORY

1. Repealer and new Article 5 filed 7–1–59; effective thirtieth day thereafter (Register 59, No. 11). For history of former Article 5, See Register 58, No. 19.
2. Amendment of Section 2730 filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
3. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
4. Repealer filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49).

§ 2731. Use of False or Fictitious Name.

(a) A licensee shall not use a fictitious name in the conduct of any activity for which a license is required under the Real Estate Law unless the licensee is the holder of a license bearing the fictitious name.

(b) The Department shall issue a license required under the Real Estate Law only in the legal name of the licensee or in the fictitious business name of a broker who presents evidence of having complied with the provisions of Sections 17910 and 17917 of the Code.

(c) The commissioner may refuse to issue a license bearing a fictitious name to a broker if the fictitious name:

(1) Is misleading or would constitute false advertising;

(2) Implies a partnership or corporation when a partnership or corporation does not exist in fact.

(3) Includes the name of a real estate salesperson.

(4) Constitutes a violation of the provisions of Sections 17910, 17910.5, 17913 or 17917 of the Code.

(5) Is the name formerly used by a licensee whose license has since been revoked.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10159.5 and 10177, Business and Professions Code.

HISTORY

1. New section filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of subsection (a), new subsections (b)–(b)(4) and subsection relettering filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).
4. Amendment of subsection (a), repealer of subsections (b)–(b)(4), subsection relettering and amendment of NOTE filed 9–22–2004; operative 10–22–2004 (Register 2004, No. 39).

§ 2732. True Name or Registered Fictitious Name on License.

HISTORY

1. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2733. Grounds for Refusal of Fictitious Name.

HISTORY

1. New section filed 2–25–60; effective thirtieth day thereafter (Register 60, No. 4).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2734. Operation by Partners from Branch Offices.

NOTE: Authority cited: Sections 10080, 10249.2 and 11001, Business and Professions Code.

HISTORY

1. New section filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Repealer filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).

Article 6. Corporate Licenses

§ 2740. Broker Officers.

No acts for which a real estate license is required may be performed for, or in the name of, a corporation when there is no officer of the corporation licensed under Section 10158 or 10211.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10132, 10158 and 10211, Business and Professions Code.

HISTORY

1. New section filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of section heading, section and NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2741. Officer Not to Have Salesperson's License.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10132, 10158, 10177(h), and 10211, Business and Professions Code.

HISTORY

1. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
3. Repealer and new section filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3).
4. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2741.5. Conditions Under Which Officer of a Licensed Corporation May Act As Salesman for It.

NOTE: Authority cited: Sections 10080, 10238.1(b), 10249.2 and 11001, Business and Professions Code. Reference: Section 10160, Business and Professions Code.

HISTORY

1. Repealer filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3). For prior history, see Register 66, No. 25.

§ 2742. Certificate of Status, Qualification or Good Standing.

(a) An applicant for an original broker license for a domestic corporation shall submit with the application, a Certificate of Status (Domestic Corporation) executed by the California Secretary of State not earlier than 30 days before the date of mailing or delivering the application to the headquarters office of the Department.

However, if the applicant is a domestic corporation which filed its original Articles of Incorporation not earlier than six (6) months before the date of mailing or delivering the application to the headquarters office of the Department, Articles of Incorporation executed by the California Secretary of State may be submitted instead of a Certificate of Status.

(b) An applicant for an original broker license for a foreign corporation shall submit with the application, a Certificate of Qualification or a Certificate of Good Standing (Foreign Corporation) executed by the California Secretary of State not earlier than 30 days before the date of mailing or delivering the application to the headquarters office of the Department.

(c) A corporation licensed under Section 10211 of the Code shall not engage in the business of a real estate broker while not in good legal standing with the Office of the Secretary of State.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10158 and 10211, Business and Professions Code.

HISTORY

1. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
2. New subsection (c) filed 4–1–93; operative 5–1–93 (Register 93, No. 14).
3. Amendment of subsection (a) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2743. Assignment of Supervisory Responsibility.

(a) A resolution assigning supervisory responsibility over salespersons licensed to a corporate broker is in compliance with Section 10159.2 of the Code if the assignment is made by reference to a specified business address or addresses of the corporate broker rather than by the listing of the names of salespersons subject to the supervision of the broker officer.

(b) In filing the resolution with the Department, the following information shall be furnished on a form prescribed by the Department:

(1) Name, business address and license number of the corporate broker.

(2) Name of the individual broker licensee who was responsible for supervision of the salespersons in question immediately preceding the effective date of the resolution.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10159.2, Business and Professions Code.

HISTORY

1. Repealer filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49). For prior history, see Register 68, No. 39.
2. New section filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).

§ 2744. Corporation License When No Remaining Licensed Officer.

HISTORY

1. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2745. Disciplinary Action Against Corporate Broker License.

NOTE: Authority cited: Sections 10080, 10248.8, 10248.9 and 11001, Business and Professions Code.

HISTORY

1. New section filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2746. Corporate Real Estate Brokers, Officers, Directors and Shareholders.

(a) At the time of application for, or in the reinstatement of, an original real estate broker license, the designated officer shall file a background statement of information for each director, the chief executive officer, the president, first level vice presidents, secretary, chief financial officer, subordinate officers with responsibility for forming policy of the corporation and all natural persons owning or controlling more than ten percent of its shares, if such person has been the subject of any of the following:

(1) Received an order or judgment issued by a court or governmental agency during the preceding 10 years temporarily or permanently restraining or enjoining any business conduct, practice or employment;

(2) Has had a license to engage in or practice real estate or other regulated profession, occupation or vocation denied, suspended or revoked during the preceding 10 years;

(3) Engaged in acts requiring a real estate license of any state without the benefit of a valid license or permit authorizing that conduct during the preceding 10 years which have been enjoined by a court of law or administrative tribunal;

(4) Been convicted of a crime which is substantially related to the qualifications, functions or duties of a licensee of the Department as specified in Section 2910 of these Regulations (excluding drunk driving, reckless driving and speeding violations).

(b) The background statement shall be set forth in DRE Form 212 and shall inquire only about the information to be disclosed pursuant to subdivision (a). The background statement must be verified and completed by each corporate officer, director or stockholder as named in subdivision (a) to the fullest extent of the signatory's actual knowledge.

(c) Whenever there is a change in the persons whose background statements are required to be on file with the Department for a corporate licensee pursuant to subdivision (a) or an addition to the persons required to file statements pursuant to subdivision (a), the designated officer of the corporation shall, within 30 days thereafter, file with the Department a background statement of information for each new or changed person.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10152, Business and Professions Code.

HISTORY

1. New section filed 7–6–89; operative 8–5–89 (Register 89, No. 31).
2. Amendment filed 3–19–90; operative 4–18–90 (Register 90, No. 13).
3. Amendment of subsection (a), new subsections (a)(1)–(a)(4), repealer and new subsection (b), amendment of subsection (c), and repealer of subsections (d)–(d)(11) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
4. Amendment of subsection (a)(2) filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

Article 7. Salesmen

§ 2750. Minimum Age.

A real state salesman license shall not be issued to a person who has not attained the age of 18 years.

HISTORY

1. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).

§ 2751. Notice to Employing Broker.

HISTORY

1. Repealer filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).

§ 2752. Notice of Change of Broker.

Whenever a real estate salesperson enters the employ of a real estate broker, the broker shall notify the commissioner of that fact within five days. This notification shall be given on a form prepared by the Department and shall be signed by the broker and the salesperson. The form of notification shall provide for the furnishing of at least the following information:

(1) Name and business address of the broker.

(2) Mailing address of the salesperson, if different from the business address.

(3) Date when the salesperson entered the employ of the broker.

(4) Certification by the salesperson that he has complied with the provisions of Section 10161.8(d) of the Business and Professions Code.

(5) Name and business address of the real estate broker to whom the salesperson was last licensed and the date of termination of that relationship.

(6) Certification by the salesperson that the predecessor broker has notice of the termination of the relationship.

As an acceptable alternative to (5) and (6) above, the form may be utilized by the predecessor broker to give notice of the termination of the broker/salesperson relationship as required by Section 10161.8(b) of the Business and Professions Code if this notice is mailed to the commissioner not more than ten days following such termination.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10161.8, Business and Professions Code.

HISTORY

1. Repealer and new section filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49). For prior history, see Register 71, No. 1.
2. Amendment of section and repealer and new NOTE filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2753. Retention of Salesperson's License Certificate.

The license certificate of a real estate salesperson licensee shall be retained at the main business office of the real estate broker to whom the salesperson is licensed. Upon the termination of employment of the salesperson, the broker shall return the license certificate to the salesperson within three business days following the termination.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10160, Business and Professions Code.

HISTORY

1. Repealer filed 7–16–64; effective thirtieth day thereafter (Register 64, No. 15).

2. New section filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3).
3. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
4. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2754. Licensees Must File Address.

HISTORY

1. New section filed 8–17–53; effective thirtieth day thereafter (Register 53, No. 14).
2. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
3. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
4. Repealer filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).

§ 2755. Salesperson Working for Partnership.

A salesperson who is licensed to a broker who is a member of a partnership acting pursuant to Section 10137.1 of the Code may perform acts for which a real estate license is required for and on behalf of the partnership.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10132 and 10137.1, Business and Professions Code.

HISTORY

1. New section filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

Article 8. Examinations

§ 2760. Notice of Time and Place.

HISTORY

1. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2761. Application for Examination.

A person desiring to take an examination for a license issued by the department shall apply to take the examination on a form furnished by the department. This form and the examination papers may require that the applicant set forth such information as is necessary to identify the applicant from among other examinees and for the purpose of correlating the application form and examination paper of each examinee.

NOTE: Authority cited: Sections 10080, 10226, 11001, 11011.8, Business and Professions Code and Section 21082, Public Resources Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3). For history of former section, see Register 71, No. 1.

§ 2761.5. Persons Not Eligible for Examination.

An examination shall not ordinarily be administered to a person who has a license or the right to the issuance of a license of the class for which the examination is to be given.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code.

HISTORY

1. New section filed 4–24–78; effective thirtieth day thereafter (Register 78, No. 17).

§ 2762. Time Allowed.

HISTORY

1. Amendment filed 8–6–54, as procedural and organizational; designated effective upon filing (Register 54, No. 17).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2763. Examination Rules.

(a) A person taking an examination for a license issued by the Department shall abide by all of the following rules from the time of entry into the examination room until the examinee has completed the examination and left the examination room:

(1) An examinee may not refer to any printed or written material other than that furnished by the Department.

(2) Written computations by examinees shall be made only on paper furnished by the Department for that purpose.

(3) An examinee may not communicate with another examinee nor with any person other than an examination proctor.

(4) The copying of questions and the making of any notes of examination materials by an examinee is prohibited.

(5) An examinee may not leave the examination room prior to completion of the examination unless express permission of an examination proctor has been obtained and all examination papers and materials have been turned over to the proctor.

(6) The only materials or devices, other than those furnished by the Department, that an examinee may use during the course of the examination are pencils and slide rules or silent, battery–operated, electronic, pocket–sized calculators which are non–programmable, do not have a print–out capability, or an alphabetic keyboard.

(7) An examinee may not share the use of examination materials with any other examinee.

(b) A violation of any of the above rules or verbal directives of an examination proctor is ground to disqualify an examinee and to initiate appropriate administrative action to deny the issuance of a license to the examinee.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10153, Business and Professions Code.

HISTORY

1. Amendment filed 12–30–70; effective thirtieth day thereafter (Register 70, No. 1).
2. Repealer and new section filed 4–24–78; effective thirtieth day thereafter (Register 78, No. 17).
3. Amendment of subsection (a) filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
4. Amendment of subsection (a)(6) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).

§ 2764. Notification of Result.

HISTORY

1. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2765. Re–Examination.

HISTORY

1. Repealer filed 2–25–60; effective thirtieth day thereafter (Register 60, No. 4).

§ 2766. Renewal License Examination.

HISTORY

1. New section filed 2–19–57; effective thirtieth day thereafter (Register 57, No. 4).
2. Repealer filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).

§ 2767. Time Limit After Renewal License Examination.

HISTORY

1. New section filed 2–19–57; effective thirtieth day thereafter (Register 57, No. 4).
2. Repealer filed 11–21–61; effective thirtieth day thereafter (Register 61, No. 23).

§ 2768. Time Limits for Taking Examinations for Renewable Licenses.

HISTORY

1. New section filed 5–16–57; effective thirtieth day thereafter (Register 57, No. 8).
2. Repealer filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).

Article 9. Signs and Advertising

§ 2770. Electronic Communication—Advertising and Dissemination of Information on the Internet.

(a) The following definitions shall apply for the purposes of this section:

(1) "Customer" means the person located within the State of California on whose behalf a service is provided or offered or to whom an advertisement is directed.

(2) "Services" means any activity for which a real estate license in required and which is offered or provided to a customer located within this state.

(b) Persons who advertise or disseminate information about services over the Internet, the World Wide Web, or similar electronic common carrier systems, will not be deemed to be engaged in the business, act in the capacity of, advertise or assume to act as a real estate broker within this state if any of the following apply:

(1) The advertisement or information involves a service but (A) is not directed to any particular person or customer located within the State of California, (B) is limited to general information about the services offered to customers or the public in general, and (C) includes the legend "The services referred to herein are not available to persons located within the State of California.".

(2) The advertisement or information does not involve a service provided in connection with activity for which a real estate license is required.

(3) The advertisement or information is not being published, circulated or transmitted on behalf of another or others.

(4)(A) The person is engaged exclusively in advertising and performs no other acts requiring a real estate license; and

(B) The person conducting the advertising does not compile or represent that he or she will compile information about specific parties in a real estate transaction. General information such as demographic or marketing information may be compiled; and

(C) The fee charged for the advertising is consistent with fees charged for similar advertising services; and

(D) The advertisements provide for direct contact between prospective parties to a real estate transaction or contact through a licensed California real estate broker.

(c) A person who advertises or disseminates information with respect to providing a service is not required to have a real estate broker license if any of the following conditions apply:

(1) The person publishing, circulating or transmitting the advertisement or disseminating the information is acting within the exemptions from the definition of real estate broker contained in Sections 10133 or 10133.1. of the Code.

(2) The services provided do not include any of the acts within the meaning of Sections 10131, 10131.1, 10131.2, 10131.3, 10131.4, 10131.45 and 10131.6 of the Code.

(3) (A) Prior to any direct electronic communication or any response or contact with a specific customer there is in place, barriers or other implemented policies and procedures, designed to ensure that prior to the response or contact, the person making it is appropriately licensed under the Real Estate Law or qualifies for an exemption from real estate broker licensure; and,

(B) There is a legend in all advertising and information disseminated about services offered indicating whether the person making the advertising or disseminating the information is a licensed California real estate broker. If the person is not a licensed California real estate broker, an additional legend shall be included which provides as follows: "The services are not available to persons located within the State of California."

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10131, 10131.1, 10131.2, 10131.3, 10131.4, 10131.45 and 10131.6, Business and Professions Code.

HISTORY

1. Repealer of section and new NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
2. New section filed 7–31–98; operative 8–30–98 (Register 98, No. 31).
3. New subsections (b)(4)–(b)(4)(D) filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2770.1. Advertising—License Designation.

Use of the terms broker, agent, Realtor, loan correspondent or the abbreviations bro., agt., or other similar terms or abbreviations, is deemed sufficient identification to fulfill the designation requirements of Section 10140.6 of the Business and Professions Code.

Use of the terms and abbreviations set forth above do not satisfy the requirements of Sections 10235.5 and 17539.4 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10140.6, 10235.5 and 17539.4, Business and Professions Code.

HISTORY

1. New section filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
2. Amendment of section and NOTE filed 4–1–93; operative 5–1–93 (Register 93, No. 14).

§ 2771. Size and Location of Sign.

HISTORY

1. Repealer filed 11–19–69; designated effective 1–2–70 (Register 69, No. 47). For prior history, see Register 68, No. 39.

§ 2771.6. Sign Requirements for Partners.

HISTORY

1. New section filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Repealer filed 11–19–69; designated effective 1–2–70 (Register 69, No. 47).

§ 2772. Wording of Sign.

HISTORY

1. New section filed 12–13–50; effective thirtieth day thereafter (Register 22, No. 4).
2. Amendment filed 9–17–65; designated effective 1–2–66 (Register 65, No. 17).
3. Repealer filed 11–19–69; designated effective 1–2–70 (Register 69, No. 47).

Article 10. Discrimination and Panic Selling

§ 2780. Discriminatory Conduct As the Basis for Disciplinary Action.

Prohibited discriminatory conduct by a real estate licensee based upon race, color, sex, religion, ancestry, physical handicap, marital status or national origin includes, but is not limited to, the following:

(a) Refusing to negotiate for the sale, rental or financing of the purchase of real property or otherwise making unavailable or denying real property to any person because of such person's race, color, sex, religion, ancestry, physical handicap, marital status or national origin.

(b) Refusing or failing to show, rent, sell or finance the purchase of real property to any person or refusing or failing to provide or volunteer information to any person about real property, or channeling or steering any person away from real property, because of that person's race, color, sex, religion, ancestry, physical handicap, marital status or national origin or because of the racial, religious, or ethnic composition of any occupants of the area in which the real property is located.

It shall not constitute discrimination under this subdivision for a real estate licensee to refuse or fail to show, rent, sell or finance the purchase of real property to any person having a physical handicap because of the presence of hazardous conditions or architectural barriers to the physically handicapped which conform to applicable state or local building codes and regulations.

(c) Discriminating because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin against any person in the sale or purchase or negotiation or solicitation of the sale or purchase or the collection of payment or the performance of services in connection with contracts for the sale of real property or in connection with loans secured directly or collaterally by liens on real property or on a business opportunity.

Prohibited discriminatory conduct by a real estate licensee under this subdivision does not include acts based on a person's marital status which are reasonably taken in recognition of the community property laws of this state as to the acquiring, financing, holding or transferring of real property.

(d) Discriminating because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin against any person in the terms, conditions or privileges of sale, rental or financing of the purchase of real property.

This subdivision does not prohibit the sale price, rent or terms of a housing accommodation containing facilities for the physically handicapped to differ reasonably from a housing accommodation not containing such facilities.

(e) Discriminating because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin against any person in pro-

viding services or facilities in connection with the sale, rental or financing of the purchase of real property, including but not limited to: processing applications differently, referring prospects to other licensees because of the prospect's race, color, sex, religion, ancestry, physical handicap, marital status or national origin, using with discriminatory intent or effect, codes or other means of identifying minority prospects or assigning real estate licensees on the basis of a prospective client's race, color, sex, religion, ancestry, physical handicap, marital status or national origin.

Prohibited discriminatory conduct by a real estate licensee under this subdivision does not include acts based on a person's marital status which are reasonably taken in recognition of the community property laws of this state as to the acquiring, financing, holding or transferring of real property.

(f) Representing to any person because of his or her race, color, sex, religion, ancestry, physical handicap, marital status or national origin that real property is not available for inspection, sale or rental when such real property is in fact available.

(g) Processing an application more slowly or otherwise acting to delay, hinder or avoid the sale, rental or financing of the purchase of real property on account of the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of a potential owner or occupant.

(h) Making any effort to encourage discrimination against persons because of their race, color, sex, religion, ancestry, physical handicap, marital status or national origin in the showing, sale, lease or financing of the purchase of real property.

(i) Refusing or failing to cooperate with or refusing or failing to assist another real estate licensee in negotiating the sale, rental or financing of the purchase of real property because of the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of any prospective purchaser or tenant.

(j) Making any effort to obstruct, retard or discourage the purchase, lease or financing of the purchase of real property by persons whose race, color, sex, religion, ancestry, physical handicap, marital status or national origin differs from that of the majority of persons presently residing in a structural improvement to real property or in an area in which the real property is located.

(k) Performing any acts, making any notation, asking any questions or making or circulating any written or oral statement which when taken in context, expresses or implies a limitation, preference or discrimination based upon race, color, sex, religion, ancestry, physical handicap, marital status or national origin; provided, however, that nothing herein shall limit the administering of forms or the making of a notation required by a federal, state or local agency for data collection or civil rights enforcement purposes; or in the case of a physically handicapped person, making notation, asking questions or circulating any written or oral statement in order to serve the needs of such a person.

(*l*) Making any effort to coerce, intimidate, threaten or interfere with any person in the exercise or enjoyment of, or on account of such person's having exercised or enjoyed, or on account of such person's having aided or encouraged any other person in the exercise or enjoyment of any right granted or protected by a federal or state law, including but not limited to: assisting in any effort to coerce any person because of his or her race, color, sex, religion, ancestry, physical handicap, marital status or national origin to move from, or to not move into, a particular area; punishing or penalizing real estate licensees for their refusal to discriminate in the sale or rental of housing because of the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of a prospective purchaser or lessee; or evicting or taking other retaliatory action against any person for having filed a fair housing complaint or for having undertaken other lawful efforts to promote fair housing.

(m) Soliciting of sales, rentals or listings of real estate from any person, but not from another person within the same area because of differences in the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of such persons.

(n) Discriminating because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin in informing persons of the existence of waiting lists or other procedures with respect to the future availability of real property for purchase or lease.

(o) Making any effort to discourage or prevent the rental, sale or financing of the purchase of real property because of the presence or absence of occupants of a particular race, color, sex, religion, ancestry, physical handicap, marital status or national origin, or on the basis of the future presence or absence of a particular race, color, sex, religion, ancestry, physical handicap, marital status or national origin, whether actual, alleged or implied.

(p) Making any effort to discourage or prevent any person from renting, purchasing or financing the purchase of real property through any representations of actual or alleged community opposition based upon race, color, sex, religion, ancestry, physical handicap, marital status or national origin.

(q) Providing information or advice to any person concerning the desirability of particular real property or a particular residential area(s) which is different from information or advice given to any other person with respect to the same property or area because of differences in race, color, sex, religion, ancestry, physical handicap, marital status or national origin of such persons.

This subdivision does not limit the giving of information or advice to physically handicapped persons for the purpose of calling to the attention of such persons the existence or absence of housing accommodation services or housing accommodations for the physically handicapped.

(r) Refusing to accept a rental or sales listing or application for financing of the purchase of real property because of the owner's race, color, sex, religion, ancestry, physical handicap, marital status or national origin or because of the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of any of the occupants in the area in which the real property is located.

(s) Entering into an agreement, or carrying out any instructions of another, explicit or understood, not to show, lease, sell or finance the purchase of real property because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin.

(t) Making, printing or publishing, or causing to be made, printed or published, any notice, statement or advertisement concerning the sale, rental or financing of the purchase of real property that indicates any preference, limitation or discrimination because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin, or any intention to make such preference, limitation or discrimination.

This subdivision does not prohibit advertising directed to physically handicapped persons for the purpose of calling to the attention of such persons the existence or absence of housing accommodation services or housing accommodations for the physically handicapped.

(u) Using any words, phrases, sentences, descriptions or visual aids in any notice, statement or advertisement describing real property or the area in which real property is located which indicates any preference, limitation or discrimination because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin.

This subdivision does not prohibit advertising directed to physically handicapped persons for the purpose of calling to the attention of such persons the existence or absence of housing accommodation services or housing accommodations for the physically handicapped.

(v) Selectively using, placing or designing any notice, statement or advertisement having to do with the sale, rental or financing of the purchase of real property in such a manner as to cause or increase discrimination by restricting or enhancing the exposure or appeal to persons of a particular race, color, sex, ancestry, physical handicap, marital status or national origin.

This subdivision does not limit in any way the use of an affirmative marketing program designed to attract persons of a particular race, color, sex, religion, ancestry, physical handicap, marital status or national origin who would not otherwise be attracted to the real property or to the area.

(w) Quoting or charging a price, rent or cleaning or security deposit for a particular real property to any person which is different from the price, rent or security deposit quoted or charged to any other person because of differences in the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of such persons.

This subdivision does not prohibit the quoting or charging of a price, rent or cleaning or security deposit for a housing accommodation containing facilities for the physically handicapped to differ reasonably from a housing accommodation not containing such facilities.

(x) Discriminating against any person because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin in performing any acts in connection with the making of any determination of financial ability or in the processing of any application for the financing or refinancing of real property.

Nothing herein shall limit the administering of forms or the making of a notation required by a federal, state or local agency for data collection or civil rights enforcement purposes. In any evaluation or determination as to whether, and under what terms and conditions, a particular lender or lenders would be likely to grant a loan, licensees shall proceed as though the lender or lenders are in compliance with Sections 35800 through 35833 of the California Health and Safety Code (The Housing Financial Discrimination Act of 1977).

Prohibited discriminatory conduct by a real estate licensee under this subdivision does not include acts based on a person's marital status which are reasonably taken in recognition of the community property laws of this state as to the acquiring, financing, holding or transferring of real property.

(y) Advising a person of the price or value of real property on the basis of factors, related to the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of residents of an area or of residents or potential residents of the area in which the property is located.

(z) Discriminating in the treatment of, or services provided to, occupants of any real property in the course of providing management services for the real property because of the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of said occupants.

This subdivision does not prohibit differing treatment or services to a physically handicapped person because of the physical handicap, marital status in the course of providing management services for a housing accommodation.

(aa) Discriminating against the owners or occupants of real property because of the race, color, sex, religion, ancestry, physical handicap, marital status or national origin of their guests, visitors or invitees.

(bb) Making any effort to instruct or encourage, expressly or impliedly, by either words or acts, licensees or their employees or other agents to engage in any discriminatory act in violation of a federal or state fair housing law.

(cc) Establishing or implementing rules that have the effect of limiting the opportunity for any person because of his or her race, color, sex, religion, ancestry, physical handicap, marital status or national origin to secure real property through a multiple listing or other real estate service.

(dd) Assisting or aiding in any way, any person in the sale, rental or financing of the purchase of real property where there are reasonable grounds to believe that such person intends to discriminate because of race, color, sex, religion, ancestry, physical handicap, marital status or national origin.

NOTE: Authority cited for Article 10, Section 10080, Business and Professions Code. Reference: Sections 125.6 and 10177, Business and Professions Code.

HISTORY

1. New Article 10 (Sections 2780–2782) filed 4–14–77; effective thirtieth day thereafter (Register 77, No. 16.) For history of former Article 10 (Sections 2775–2777), see Register 69, No. 47.
2. Amendment filed 4–24–78; effective thirtieth day thereafter (Register 78, No. 17).
3. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2781. Panic Selling As the Basis for Disciplinary Action.

Prohibited discriminatory conduct includes, but is not limited to, soliciting sales or rental listings, making written or oral statements creating fear or alarm, transmitting written or oral warnings or threats, or acting in any other manner so as to induce or attempt to induce the sale or lease of real property through any representation, express or implied, regarding the present or prospective entry of one or more persons of another race, color, sex, religion, ancestry, marital status or national origin into an area or neighborhood.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 125.6, Business and Professions Code.

HISTORY

1. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2782. Duty to Supervise.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 125.6, 10159.2, and 10177(h), Business and Professions Code.

HISTORY

1. Amendment filed 4–24–78; effective thirtieth day thereafter (Register 78, No. 17).
2. Amendment of subsection (a) filed 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
3. Repealer of section and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 11. Code of Ethics and Professional Conduct

§ 2785. Professional Conduct.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10176 and 10177, Business and Professions Code.

HISTORY

1. Repealer of article 11 (section 2781) filed 4–14–77; effective thirtieth day thereafter (Register 77, No. 16). For prior history, see Register 63, No. 14.
2. New article 11 (section 2785) filed 7–26–79; effective thirtieth day thereafter (Register 79, No. 30).
3. Amendment filed 5–18–81; effective thirtieth day thereafter (Register 81, No. 21).
4. New subsections (a)(12) and (13) filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
5. Repealer and new section filed 5–9–90; operative 6–8–90 (Register 90, No. 25).
6. Amendment of subsection (a)(20) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
7. Amendment of subsection (a)(14), repealer of subsection (a)(20), amendment of subsections (b)(2)(A) and (b)(3), (6) and (9) filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
8. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 12. Subdivisions

§ 2790. Application for Public Report.

An application for a public report whether it includes a completed questionnaire or consists only of a notice of intention shall be made on a form prescribed by the Department and shall be submitted to the Department with the applicable filing fee. The application shall be executed by or on behalf of the person to whom the public report is to be issued. If executed within California, the information in the application and the documents submitted therewith shall be certified to be true under penalty of perjury or verified before a notary public or other person qualified to administer oaths. If executed outside of California, the information in the application and accompanying documents shall be verified before a person qualified to administer oaths within the jurisdiction where executed,

or certified under penalty of perjury in accordance with the provisions of subdivision (b) of Section 2015.5 of the Code of Civil Procedure.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11010 and 11011, Business and Professions Code.

HISTORY

1. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Amendment filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment of subsection (a) filed 11–11–84; effective thirtieth day thereafter (Register 84, No. 2).
5. Amendment filed 2–26–85; effective thirtieth day thereafter (Register 85, No. 9).

§ 2790.1. Filing Fees.

NOTE: Authority cited: Sections 11001 and 11011, Business and Professions Code. Reference: Sections 11004.5, 11010 and 11011, Business and Professions Code.

HISTORY

1. Amendment filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3). For prior history, see Register 74, No. 49.
2. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
4. Amendment filed 12–22–81; designated effective 2–1–82 (Register 81, No. 52).
5. Amendment filed 8–10–82; effective thirtieth day thereafter (Register 82, No. 33).
6. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
7. Amendment of section and NOTE filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
8. New subsection (c) and amendment of NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
9. Amendment and redesignation of first paragraph as subsection (a), new subsections (a)(1)–(a)(11), and subsection relettering filed 6–18–98; operative 8–1–98. Submitted to OAL for printing only pursuant to Business and Professions Code section 10226 (Register 98, No. 26).
10. Amendment of subsections (a)(2)–(3) and (a)(8)–(11) filed 6–1–99; amended and refiled 7–14–99; operative 8–1–99. Submitted to OAL for printing only pursuant to Business and Professions Code section 10226 (Register 99, No. 29).
11. Amendment of subsections (a)(2), (a)(3) and (a)(8)–(11) filed 5–16–2001; operative 6–15–2001 (Register 2001, No. 20).
12. Amendment of subsection (d) filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).
13. Repealer filed 5–1–2007; operative 5–31–2007 (Register 2007, No. 18).

§ 2790.1.5. Filing Fees.

(a) The subdivision filing fees for an application for a public report shall be the following:

(1) A notice of intention without a completed questionnaire: One hundred fifty dollars ($150).

(2) An original public report for subdivision interests described in Section 11004.5: One thousand six hundred dollars ($1,600) plus ten dollars ($10) for each subdivision interest to be offered.

(3) An original public report for subdivision interests other than those described in Section 11004.5: Five hundred dollars ($500) plus ten dollars ($10) for each subdivision interest to be offered.

(4) A conditional public report for subdivision interests described in Section 11004.5: Five hundred dollars ($500).

(5) A conditional public report for subdivision interests other than those described in Section 11004.5: Five hundred dollars ($500).

(6) A preliminary public report for subdivision interests described in Section 11004.5: Five hundred dollars ($500).

(7) A preliminary public report for subdivision interests other than those described in Section 11004.5: Five hundred dollars ($500).

(8) A renewal public report for subdivision interests described in Section 11004.5: Five hundred dollars ($500).

(9) A renewal public report for subdivision interests other than those described in Section 11004.5: Five hundred dollars ($500).

(10) An amended public report for subdivision interests described in Section 11004.5: Three hundred dollars ($300) plus ten dollars ($10) for each subdivision interest to be offered under the amended public report for which a fee has not previously been paid.

(11) An amended public report to offer subdivision interests other than those described in Section 11004.5: Three hundred dollars ($300) plus ten dollars ($10) for each subdivision interest to be offered under the amended public report for which a fee has not previously been paid.

(b) The maximum fee under Section 11011(b)(2) and (b)(10) shall be $7,600 regardless of the number of interests authorized to be offered for sale or lease.

(c) The maximum fee under Section 11011(b)(3) and (b)(11) shall be $4,100 regardless of the number of interests authorized to be offered for sale or lease.

(d) The filing fee for an amended public report where the amendment consists only of a recurring and non–substantive change including, but not limited to a change in the name of the subdivider shall be $125 and the filing fee for each additional amended public report consisting only of the same recurring and non–substantive change including, but not limited to a change in the name of the subdivider submitted by that subdivider at the same time shall be $60. The subsection does not apply where there is a change in the ownership of the subdivision along with a change in the name of the subdivider.

NOTE: Authority cited: Sections 11001 and 11011, Business and Professions Code. Reference: Sections 11004.5, 11010 and 11018.5, Business and Professions Code.

HISTORY

1. New section filed 7–15–2003; operative 8–31–2003 (Register 2003, No. 29).
2. Amendment of subsection (a) and repealer of subsection (e) filed 5–1–2007; operative 5–31–2007 (Register 2007, No. 18).

§ 2790.2. Conditional Public Reports.

(a) An applicant for an original, renewed or amended Final Public Report for a subdivision of the type not described in Section 11000.1 of the Code may also apply for a Conditional Public Report for the subdivision.

(b) An applicant for a Conditional Public Report shall submit the following information and documents with the applicable filing fee:

(1) A copy of the statement set forth in Section 11018.12(f) which the applicant proposes to use.

(2) An exemplar sales agreement or lease to be used in any transaction conducted under authority of the Conditional Public Report. Such sales agreement or lease shall include the following provisions:

(A) As a condition of the sale or lease that no escrow will close, funds will not be released from escrow and the interest contracted for will not be conveyed until a current Final Public Report for the subdivision is furnished to the purchaser.

(B) The return of the entire sum of money paid or advanced by the purchaser if a Final Public Report for the subdivision has not been issued within six months of the date of issuance of the Conditional Public Report or the purchaser or lessee is dissatisfied with the Final Public Report because of a change pursuant to Section 11012.

(3) An exemplar of escrow instructions to be used in any transaction conducted under authority of the Conditional Public Report which includes at least the following:

(A) The name and address of the escrow depository.

(B) A description of the nature of the transaction.

(C) Provisions ensuring compliance with Section 11013.2(a) or 11013.4(a) of the Code.

(D) Provisions ensuring that no escrow will close, funds will not be released from escrow and the interest contracted for will not be conveyed until a current Final Public Report for the subdivision is furnished to the purchaser or lessee.

(E) Provisions for the return of money as prescribed in subsection (2)(B) above.

(4) For a subdivision described in Section 11004.5 of the Code, in addition to the requirements set forth above:

(A) Information and documents demonstrating that reasonable arrangements have been made to assure completion of the subdivision and all offsite improvements included in the offering.

(B) Information and documents demonstrating that the applicant has complied with Section 11018.5(a)(2) of the Code for the subdivision.

(c) A Conditional Public Report will not be issued unless the applicant has met the requirements set forth in Section 11018.12 of the Code.

(d) Written notice of the decision to deny issuance of a Conditional Public Report will be mailed to the applicant, pursuant to Section 11018.12(c) of the Code, within five business days after the Commissioner decides not to issue a Conditional Public Report.

(e) The term of a Conditional Public Report will not exceed six months, but the Conditional Public Report may be renewed for one additional six-month period if the Commissioner determines that the requirements for issuance of a public report are likely to be satisfied during the renewal term.

(f) The Commissioner may issue a conditional permit for a subdivision as defined in Section 10250.1 in accordance with the provisions of subsections (a) through (e), above.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 10250.1, 11010.2, 11011 and 11018.12, Business and Professions Code.

HISTORY

1. New section filed 3-1-94; operative 3-31-94 (Register 94, No. 9). For prior history, see Register 85, No. 2.
2. Amendment of subsection (c), repealer of subsections (c)(1)-(c)(2), new subsection (f) and amendment of NOTE filed 7-10-97; operative 7-10-97 pursuant to Government Code section 11343.4(d) (Register 97, No. 28).
3. Amendment of subsections (a), (b)(3)(E) and (f) filed 10-26-99; operative 11-25-99 (Register 99, No. 44).

§ 2790.4. Questionnaire Waiver—Rural Housing Service.

The submission of a completed questionnaire shall be waived pursuant to subdivision (c) of Section 11010 of the Code for a proposed subdivision offering that satisfies all of the following criteria:

(a) Except as provided in (d) below, the division of the land is not a subdivision as defined in Sections 11000.1, or 11004.5 of the Code.

(b) The financing of the purchase or lease of lots and parcels will be provided exclusively by the Rural Housing Service pursuant to Section 502 of the Housing Act of 1949 (42 U.S.C. Section 1472) as amended.

(c) Lots and parcels will be developed and improved with residential structures exclusively through technical assistance grants to nonprofit agencies pursuant to Section 523 of the Housing Act of 1949 (42 U.S.C. Section 1490(c)) as amended.

(d) If the proposed offering is a planned development subdivision within the meaning of subdivision (a) of Section 11004.5 of the Code, the submission of a completed questionnaire shall be waived if the applicant, pursuant to subdivision (b)(14) of Section 11010 of the Code, submits the following for the subdivision:

(1) Governing instruments for the subdivision and the association of owners.

(2) Detailed budget reflecting estimated costs of ownership, operation and maintenance expenses and reserves for the subdivision.

(3) Evidence that common areas and facilities have been or will be conveyed free of liens and encumbrances, to the association of owners or to the owners as tenants in common.

NOTE: Authority cited: Sections 11001 and 11010, Business and Professions Code. Reference: Sections 11010 and 11011, Business and Professions Code.

HISTORY

1. New section filed 2-1-84; designated effective 2-10-84 pursuant to Government Code Section 11346.2(d) (Register 84, No. 5).
2. Amendment filed 2-26-85; effective thirtieth day thereafter (Register 85, No. 9).
3. Amendment of section heading and subsection (b) filed 11-27-96; operative 12-27-96 (Register 96, No. 48).
4. Amendment of subsection (a) filed 10-26-99; operative 11-25-99 (Register 99, No. 44).

§ 2790.5. Phased Senior Citizen Housing Developments.

(a) An applicant for a public report may qualify a proposed project as a senior citizen housing development, even though there are an insufficient number of dwelling units in the initial phase of the project to satisfy the statutory definition of the term as set forth in Section 51.3 of the Civil Code, by complying with the provisions of Section 11010.05 of the Code.

(b) The submission of documentation of the following items shall be deemed to have satisfied the requirements of subdivision (c) of Section 11010.05 of the Code.

(1) A preliminary title report or policy of title insurance showing that the applicant holds fee title, a long-term leasehold interest, or other evidence of controlling interest in the property to be annexed to the first phase, and any subsequent phase, of the subdivision, such as an irrevocable option, as being vested in the applicant.

(2) A covenant, recorded in the office of the appropriate county recorder, limiting use on the land proposed to be annexed to a senior citizen housing development.

(3) A certification from the appropriate local authority that the land proposed to be annexed is sufficient in size to construct the number of additional units necessary to qualify the project as a senior citizen housing development as that term is defined in Section 51.3(b)(4) of the Civil Code.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11010.05(c), Business and Professions Code.

HISTORY

1. New section filed 4-1-86; effective thirtieth day thereafter (Register 86, No. 14). For history of former section, see Registers 83, No. 30; 76, No. 3; 63, No. 14; and 53, No. 14.
2. Repealer of subsection (c) filed 10-26-99; operative 11-25-99 (Register 99, No. 44).
3. Amendment of subsection (a) filed 11-9-2000; operative 12-9-2000 (Register 2000, No. 45).
4. Amendment of subsection (b)(3) filed 9-5-2003; operative 10-5-2003 (Register 2003, No. 36).

§ 2790.6. Separate Review of Declarations.

The filing fee to review a declaration as described in Section 11010.10 of the Code shall be the maximum fee set forth in Section 11011 of the Code.

NOTE: Authority cited: Sections 11001 and 11011, Business and Professions Code. Reference: Section 11010.10, Business and Professions Code.

HISTORY

1. New section filed 6-20-2002; operative 7-20-2002 (Register 2002, No. 25). For prior history, see Register 61, No. 15.

§ 2790.7. General Housing Information — For Research and Statistical Purposes.

As a part of any application required by Section 11010 of the Code (application), each applicant for a final subdivision public report shall, prior to the issuance of the final subdivision public report, complete and submit general housing information to be used solely for statistical and research purposes. Evidence of submission of the information shall be included in the application file, but the information is not a part of the application or its file. A copy of the information will not be included or retained in the application or its file. The information will not be used in any decision controlling the issuance of any public report. Once submitted, the data provided will be incorporated into the statistical database, and the original information provided will be permanently deleted. Unless otherwise established by an amendment to this regulation, the applicant must provide only the following information: the city and/or county in which the subdivision is located; the zip code; the total acreage; the estimated average number of lots, units or parcels proposed for each phase; whether lots, units or parcels will be offered vacant or with completed residential structures; the anticipated date of the first close of escrow; the estimated average lot/parcel size; the estimated average sale price of the lots, units or parcels; the number of bedrooms, the estimated average square footage and parking arrangements for the residential structures; the prior use of the property (improved or unimproved); and, if the applicant originally entitled the project, the number of lots, units or parcels requested of local government and the total number of lots, units or parcels approved by local government.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11010, Business and Professions Code.

HISTORY

1. New section filed 8-2-2006; operative 9-1-2006 (Register 2006, No. 31). For prior history, see Register 85, No. 2.

§ 2790.8. Existing Subdivision Interest Disclosure.

(a) An applicant for a public report for the sale or lease of an existing subdivision interest shall include an Existing Subdivision Interest Disclosure Statement with the public report application.

(b) The Existing Subdivision Interest Disclosure Statement shall be completed and provided by the Subdivider/Seller (Seller) to each buyer as soon as practicable before the transfer of title.

(c) If any Existing Subdivision Interest Disclosure required by this Section is delivered after the execution of an offer to purchase, the buyer shall have three days after delivery in person or five days after delivery by deposit in the mail, to terminate the purchase agreement by delivery of a written notice of termination to the Seller.

(d) The Seller is obligated to disclose information in the Existing Subdivision Interest Disclosure based on Seller's actual knowledge, after making a reasonable effort to obtain such information, whether derived from Seller's own investigation and inspection of the Existing Subdivision Interest or from written reports prepared by third parties retained by Seller to perform inspections.

(e) The Seller shall amend any information in an Existing Subdivision Interest Disclosure after the Disclosure is provided to the buyer, if the information in the Disclosure is or becomes materially inaccurate and the Seller has actual knowledge of the inaccuracy. The Seller is otherwise not required to amend the Disclosure once it has been provided to the Buyer. A buyer shall have the right to terminate a purchase agreement based on an amended Disclosure if the amended Disclosure shows that the original Disclosure was inaccurate or has become inaccurate in any material respect. Buyer shall have three days after delivery in person or five days after delivery by deposit in the mail of the amended Disclosure to terminate the purchase agreement by delivery of a written notice of termination to the Seller.

(f) The term "Existing Subdivision Interest" as used in this section is a subdivision interest described in Section 11004.5 of the Code where the dwelling comprising the subdivision interest has been completed (completion is normally the date on which a Notice of Completion has been recorded evidencing completion of the improvement) or occupied (the occupancy of the improvements is normally the date shown by the issuance of a Certificate of Occupancy or equivalent issued by the local jurisdiction), whichever occurs first, three (3) years or more before the date that the public report application is filed with the Department.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 10050 and 11010, Business and Professions Code.

HISTORY

1. New section filed 2-14-2008; operative 3-15-2008 (Register 2008, No. 7). For prior history, see Register 85, No. 2.

§ 2790.9. Existing Subdivision Interest Disclosure Form.

The form approved by the Commissioner for the disclosure of Existing Subdivision Interest information is as follows:

EXISTING SUBDIVISION INTEREST DISCLOSURE STATEMENT

THIS EXISTING SUBDIVISION INTEREST DISCLOSURE STATEMENT (THIS "*DISCLOSURE STATEMENT*") CONCERNS THE REAL PROPERTY SITUATED IN THE CITY OF_____, COUNTY OF _____, STATE OF CALIFORNIA, DESCRIBED AS _____ (THE "*EXISTING SUBDIVISION INTEREST*"). THIS STATEMENT IS A DISCLOSURE OF THE CONDITION OF THE EXISTING SUBDIVISION INTEREST AS OF (date) _____, 20___, WITHIN THE SELLER'S ACTUAL KNOWLEDGE. IT IS NOT A REPRESENTATION OR WARRANTY OF ANY KIND BY THE SELLER(S) OR ANY AGENT(S) REPRESENTING ANY PRINCIPAL(S) IN THIS TRANSACTION, AND IS NOT A SUBSTITUTE FOR ANY INSPECTIONS OR WARRANTIES THE BUYER(S) MAY WISH TO OBTAIN.

I. COORDINATION WITH OTHER DISCLOSURE FORMS AND EXISTING REPORTS

All parties acknowledge that the real property being purchased is a lot, condominium unit or other interest in the Existing Subdivision Interest (the "***Property***") and the Seller hereby discloses to the Buyer in this transaction that the following inspection reports, if any, regarding the Property were completed and are or have been in the possession of the Seller:

	Description/type	*Vendor (by)*	*Date on Report*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Buyer may request a copy of any of the reports listed above in writing within 5 days after receipt of this Disclosure Statement.

The following disclosures and other disclosures required by law, applicable to the condition of the Property, have or will be made in connection with this real estate transfer, and shall satisfy the disclosure obligations on this form, where the subject matter is the same.

☐ Inspection reports completed pursuant to the contract of sale or receipt for deposit.

☐ Additional inspection reports or disclosures:

_____

_____

_____

_____

The disclosures and reports identified in this Section are collectively called the "Existing Disclosures."

II. SELLER'S INFORMATION

The Seller discloses the following information with the knowledge that this is not a representation or warranty. Seller hereby authorizes any agent(s) representing any principal(s) in this transaction to provide a copy of this statement to any person or entity in connection with any actual or anticipated sale of the Property.

The information disclosed in this Disclosure Statement is limited to information which Seller actually knows, based on reasonable efforts to obtain such information. The phrases "Seller's knowledge" and "Seller's awareness" when used herein, are limited accordingly.

THE FOLLOWING ARE DISCLOSURES MADE BY THE SELLER AND ARE NOT THE DISCLOSURES OF THE AGENT(S), IF ANY. THIS INFORMATION IS A DISCLOSURE AND IS NOT PART OF ANY CONTRACT BETWEEN THE BUYER AND SELLER,

Seller or Seller's tenant ☐ is ☐ is not occupying the Property.

A. The Property has the items checked below (**read across**):

☐ Range	☐ Oven	☐ Microwave
☐ Dishwasher	☐ Trash Compactor	☐ Garbage Disposal
☐ Washer/Dryer Hookups	☐ Rain Gutters	☐ Burglar Alarms
☐ Smoke Detector(s)	☐ Fire Alarm	☐ TV Antenna
☐ Satellite Dish	☐ Intercom	☐ Central Heating
☐ Central Air Cndtng.	☐ Evaporator Cooler(s)	☐ Wall/Window Air Cndtng.
☐ Sprinklers	☐ Public Sewer System	☐ Septic Tank
☐ Sump Pump	☐ Water Softener	☐ Patio/Decking
☐ Built-in Barbecue	☐ Gazebo	☐ Sauna
☐ Hot Tub ☐ Locking Safety Cover*	☐ Pool ☐ Child Resistant Barrier*	☐ Spa ☐ Locking Safety Cover*
☐ Security Gate(s)	☐ Automatic Garage Door Opener(s)	☐ Number Remote Controls
Garage: ☐ Attached	☐ Not Attached	☐ Carport
Pool/Spa Heater: ☐ Gas	☐ Solar	☐ Electric
Water Heater: ☐ Gas	☐ Water Heater: Anchored, Braced, or Strapped*	☐ Private Utility or Other _____

Water Supply: ☐ City ☐ Well
Gas Supple: ☐ Utility ☐ Bottled
☐ Window Screen ☐ Window Security Bars ☐ Quick Release Mechanism on Bedroom Windows*

Exhaust Fans(s) in _____
220 Volt Wiring in _____
Fireplace(s) in _____
☐ Gas Starter ☐ Roof(s): Type: _____
Age: (approx.) _____
☐ Other _____

To Seller's actual knowledge, are any of the above not in operating condition?

☐ Yes ☐ No. If yes, then describe.
(Attach additional sheets if necessary): _____

B. To Seller's actual knowledge, are there any significant defects/malfunctions in any of the following?

☐ Yes ☐ No. If yes, check appropriate space(s) below.

☐ Interior Walls ☐ Ceilings ☐ Floors
☐ Exterior Walls ☐ Insulation ☐ Roofs(s)
☐ Windows ☐ Doors ☐ Foundation
☐ Slab(s) ☐ Driveways ☐ Sidewalks
☐ Walls/Fences ☐ Electrical Systems ☐ Plumbings/Sewers/Septics

☐ Other Structural components
(Describe:

If any of the above is checked, explain (attach additional sheets if necessary):

* The garage door opener or child resistant pool barrier may not be in compliance with the safety standards relating to automatic reversing devices as set forth in Chapter 12.5 (commencing with Section 19890) of Part 3 of Division 13 of, or with the pool safety standards of Article 2.5 (commencing with Section 115920) of Chapter 5 of Part 10 of Division 104 of, the Health and Safety Code. The water heater may not be anchored, braced, or strapped in accordance with Section 19211 of the Health and Safety Code. Window security bars may not have quick-release mechanisms in compliance with the 1995 edition of the California Building Standards Code.

C. Does Seller have actual knowledge of any of the following:

1. Substances, materials or products which may be an environmental hazard such as, but not limited to, asbestos, formaldehyde, radon gas, lead-based paint. mold, fuel or chemical storage tanks, and contaminated soil or water on the subject property Yes No
2. Features of the property shared in common with adjoining landowners, such as walls, fences, and driveways, whose use or responsibility for maintenance may have an effect on the subject property Yes No
3. Any encroachments, easements or similar matters that may affect your interest in the subject property Yes No
4. Room additions, structural modifications, or other alterations or repairs made without necessary permits Yes No
5. Room additions, structural modifications, or other alterations or repairs not in compliance with building codes Yes No
6. Fill (compacted or otherwise) on the property or any portion thereof Yes No
7. Any settling from any cause, or slippage, sliding, or other soil problems Yes No
8. Flooding, drainage or grading problems Yes No
9. Major damage to the property or any of the structures from fire, earthquake, floods, or landslides Yes No
10. Any zoning violations, nonconforming uses, violations of "setback" requirements Yes No
11. Neighborhood noise problems or other nuisances Yes No
12. CC&Rs or other deed restrictions or obligations Yes No
13. Homeowners' Association which has any authority over the subject property Yes No
14. Any "common area" (facilities such as pools, tennis courts, walkways, or other areas co-owned in undivided interest with others) Yes No
15. Any notices of abatement or citations against the property Yes No
16. Any lawsuits by or against the Seller threatening to or affecting this real property, including any lawsuits alleging a defect or deficiency in this real property or "common areas" (facilities such as pools, tennis courts, walkways, or other areas co-owned in undivided interest with others) Yes No

If the answer to any of these is yes and they are not included in the preliminary title report, explain. (Attach additional sheets if necessary.)

The information herein is true and correct to the Seller's actual knowledge, as of the date signed by the Seller or Seller's representative.

Seller _____
Date _____

BUYER(S) MAY WISH TO OBTAIN PROFESSIONAL ADVICE AND/OR INSPECTIONS OF THE PROPERTY AND TO PROVIDE FOR APPROPRIATE PROVISIONS IN A CONTRACT BETWEEN BUYER(S) AND SELLER(S) WITH RESPECT TO ANY ADVICE/INSPECTION/DEFECTS.

I/WE ACKNOWLEDGE RECEIPT OF A COPY OF THIS STATEMENT.

BUYER _____ DATE _____

BUYER _____ DATE _____

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 10050 and 11010, Business and Professions Code.

HISTORY

1. New section filed 2-14-2008; operative 3-15-2008 (Register 2008, No. 7).

§ 2791. Purchase Money Disbursements.

(a) The Contract proposed to be used by an applicant for a public report (Subdivider) for the sale or lease of subdivision interests shall provide that if the escrow for sale or lease of a subdivision interest does not close on or before the date set forth in the contract, or a later closing date mutually agreed to by subdivider and the prospective buyer or lessee (Buyer), within 15 days after the closing date set forth in the contract or an extended closing date mutually agreed to by Subdivider and Buyer, Subdivider shall, except as provided in subdivision (c), order all of the money remitted by Buyer under the terms of the Contract for acquisition of the subdivision interest (Purchase Money) to be refunded to Buyer.

(b) The Contract may provide for disbursements or charges to be made against Purchase Money for payments to third parties for credit reports, escrow services, preliminary title reports, appraisals and loan processing services by such parties provided that the Contract includes:

(1) specific enumeration of all of the disbursements or charges that may be made against Purchase Money, and

(2) the Subdivider's estimate of the total amount of such disbursements and charges.

(c)(1) Any contractual provision which calls for disbursement or a charge against Purchase Money based upon Buyer's alleged failure to complete the purchase of the subdivision interest must conform with Civil Code Sections 1675 (including either subsection (c) or subsection (d) thereof), 1676, 1677 and 1678.

(2) Except for a disbursement made following substantial compliance with the procedures set forth in paragraph (4) below or pursuant to a written agreement of the parties which either cancels the Contract or is executed after the final closing date specified by the parties, a disbursement or charge against Purchase Money as liquidated damages may be done only pursuant to a determination by a court of law, or by an arbitrator if

the parties have so provided by contract, that Subdivider is entitled to a disbursement or charge against Purchase Money as liquidated damages.

(3) A contractual provision for a determination by arbitration that Subdivider is entitled to a disbursement or charge against Purchase Money as liquidated damages shall require that the arbitration be conducted in accordance with procedures that are equivalent in substance to the commercial arbitration rules of the American Arbitration Association, that any arbitration include every cause of action that has arisen between Buyer and Subdivider under the Contract, and that the Subdivider remit the fee to initiate arbitration with the costs of the arbitration ultimately to be borne as determined by the arbitrator.

(4) The contract of sale may include a procedure under which Purchase Money may be disbursed by the escrow holder to the Subdivider as liquidated damages upon Buyer's failure to timely give the escrow holder Buyer's written objection to disbursement of Purchase Money as liquidated damages. This procedure shall contain at least the following elements:

(A) The Subdivider shall give written notice, in the manner prescribed by Section 116.340 of the Code of Civil Procedure for service in a small claims action, to escrow holder and to Buyer that Buyer is in default under the Contract and that Subdivider is demanding that escrow holder remit $_____ from the Purchase Money to Subdivider as liquidated damages unless, within 20 days, Buyer gives escrow holder Buyer's written objection to disbursement of Purchase Money as liquidated damages.

(B) Buyer shall have a period of 20 days from the date of receipt of the Subdivider's 20–day notice and demand in which to give escrow holder Buyer's written objection to disbursement of Purchase Money as liquidated damages.

(5) The Contract may not make Buyer's failure to timely give the escrow holder the aforesaid written objection a waiver of any cause of action, other than a waiver of the right to specific performance of the contract, that the Buyer may have against the Subdivider under the Contract unless the waiver is conditioned upon service of the Subdivider's 20–day notice and demand in a manner prescribed by Section 116.340 of the Code of Civil Procedure for service in a small claims action.

(6) If the Subdivider has had the use of Purchase Money pending consummation of the sale or lease transaction under authorization by the Department pursuant to subdivision (c) or (d) of Section 11013.2 of the Code or subdivision (b) or (c) of Section 11013.4 of the Code, Subdivider shall immediately upon alleging the default of Buyer, transmit to the escrow holder, funds equal to all of the Purchase Money paid by Buyer.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.2 and 11013.4, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49). For history of former section, see Register 71, No. 50.
2. Amendment filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
3. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
4. Amendment of subsection (c)(3) filed 7–31–98; operative 8–30–98 (Register 98, No. 31).
5. Amendment of subsections (c)(1) and (c)(5) filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2791.1. Purchase Money Impounds.

(a) The amount of the money paid or advanced by a prospective buyer or lessee toward the purchase or lease of a subdivision interest (Purchase Money) that must be deposited and retained in an escrow depository or trust account pursuant to Section 11013.2(a) or 11013.4(a) of the Code shall ordinarily be the entire amount of the Purchase Money less disbursements made to third parties for services enumerated in subdivision (b) of Regulation 2791.

(b) For purposes of compliance with Section 11013.2(a) of the Code:

(1) A proper release has not ben obtained from a deed of trust encumbering subdivision lots or parcels unless an instrument has been duly recorded unconditionally reconveying and releasing the lot or lots being sold or leased from the lien or charge of such deed of trust.

(2) As an alternative to obtaining a proper release from the lien or charge of such deed of trust, it shall be deemed acceptable by the commissioner, pursuant to the provisions of Section 11013.2(d) of the Code, if:

(A) the holder of the deed of trust has duly executed an agreement or demand ("release agreement") wherein the holder has agreed, notwithstanding any provision to the contrary in the deed of trust, to promptly perform any act reasonably necessary to record an instrument unconditionally reconveying and releasing the subdivision lots or parcels being sold from the lien or charge of the deed of trust upon payment to the holder of an amount or amounts specified in the release agreement as the release price for the affected subdivision lots or parcels, and the holder has further agreed that specific performance of the terms and provisions of the release agreement shall be compelled in favor of the purchaser or lessee of the lot or lots;

(B) the release agreement has been deposited with the escrow holder for the transaction(s);

(C) the subdivider has notified each purchaser or lessee that the release agreement is available upon request from the escrow holder; and

(D) each purchaser or lessee has been provided a policy of title insurance insuring the purchaser or lessee against loss by reason of the deed of trust.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.1 and 11013.4, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49). For history of former section, see Registers 63, No. 14, and 62, No. 7.
2. Amendment filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
3. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2791.2. Bond Alternative to Purchase Money Impound.

The penal sum of a bond or bonds furnished by or on behalf of a subdivider pursuant to Section 11013.2(c) or Section 11013.4(b) or (c) of the Code shall ordinarily be not less than the aggregate amount of the money paid or advanced toward the purchase or lease of subdivision interests for which the subdivider is accountable to prospective purchasers or lessees less the sum of the amount held in escrow depositories or trust accounts pursuant to Section 11013.2(a) or Section 11013.4(a) of the Code and the disbursements made to third parties for services enumerated in subdivision (b) of Regulation 2791.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.2 and 11013.4, Business and Professions Code.

HISTORY

1. Repealer and new section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49). For prior history, see Register 65, No. 17.
2. Amendment filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).

§ 2791.3. Lien and Completion Bonds for Onsite Construction Work.

The penal sum of a bond or bonds furnished by or on behalf of a subdivider pursuant to Section 11013.4(d)(2) of the Code shall ordinarily be not less than 120 percent of the estimate of the total cost of the onsite construction work to be completed on the subdivision interest being offered for sale or lease.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11013.4, Business and Professions Code.

HISTORY

1. New section filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36). For prior history, see Register 96, No. 46.

§ 2791.4. Acceptable Escrow Depositories.

(a) The following entities which are qualified to do business in the State of California are escrow depositories acceptable to the Commissioner under Sections 11013.2 and 11013.4 of the Code: escrow agents licensed by the Corporations Commissioner, banks, trust companies, savings and loan associations, title insurers and underwritten title companies.

(b) In exceptional circumstances the Commissioner may approve an escrow depository other than an entity enumerated in subdivision (a).

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.2, 11013.4, Business and Professions Code.

HISTORY

1. Repealer and new section filed 12–3–80 effective thirtieth day thereafter (Register 80, No. 49). For prior history, see Register 77, No. 49.

§ 2791.6. Acceptable Trustees.

A trust company as defined in Section 107 of the Financial Code which is qualified to do business in California is a trustee acceptable to the Commissioner to hold title to a subdivision under Section 11013.2(b) and other applicable provisions of the Subdivided Lands Law. In exceptional circumstances the Commissioner may approve a trustee other than a trust company as defined in Section 107 of the Financial Code.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11013.2, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2791.7. Purchase Money Protection for Exempt Subdivisions.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.2 and 11013.4, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
2. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2791.8. Dispute Resolution.

(a) A contractual provision setting forth terms, conditions and procedures for resolution of a dispute or claim between a homeowner and a subdivider, or a provision in the covenants, conditions and restrictions setting forth terms, conditions and procedures for resolution of a dispute of claim between a homeowners association and a subdivider shall, at a minimum, provide that the dispute or claim resolution process, proceeding, hearing or trial to be conducted in accordance with the following rules:

(1) For the subdivider to advance the fees necessary to initiate the dispute or claim resolution process, with the costs and fees, including ongoing costs and fees, if any, to be paid as agreed by the parties and if they can't agree then the costs and fees are to be paid as determined by the person or persons presiding at the dispute or claim resolution proceeding or hearing.

(2) For a neutral or impartial person(s) to administer and preside over the claim or dispute resolution process.

(3) For the appointment, or selection, as designation, or assignment of the person(s) to administer and preside over the claim or dispute resolution process within a specific period of time, which in no event shall be more than sixty (60) days from initiation of the claim or dispute resolution process or hearing. The person(s) appointed, selected, designated or assigned to preside may be challenged for bias.

(4) For the venue of the claim or dispute resolution process to be in the county where the subdivision is located unless the parties agree to some other location.

(5) For the prompt and timely commencement of the claim or dispute resolution process. When the contract provisions provide for a specific type of claim or dispute resolution process, the process shall be deemed to be promptly and timely commenced if it is to be commenced in accordance with the rules applicable to that process, or if the rules don't specify a date by which the proceeding or hearing must commence, then to a date agreed upon by the parties, and if they cannot agree, a date determined by the person(s) presiding over the dispute resolution process.

(6) For the claim or dispute resolution process to be conducted in accordance with rules and procedures that are reasonable and fair to the parties.

(7) For the prompt and timely conclusion of the claim or dispute resolution process, including the issuance of any decision or ruling following the proceeding or hearing.

(8) For the person(s) presiding at the claim or dispute resolution process to be authorized to provide all recognized remedies available in law or equity for any cause of action that is the basis of the proceeding or hearing. The parties may authorize the limitation or prohibition of punitive damages.

(b) A copy of the rules applicable to the claim or dispute resolution process shall be submitted as part of the application for a public report.

(c) If the claim or dispute resolution process provides or allows for a judicial remedy in accordance with the laws of this state, it shall be presumed that the proceeding or hearing satisfies the provisions of paragraph (a).

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 6–15–98; operative 7–15–98 (Register 98, No. 25). For prior history see Register 96, No. 46.
2. Amendment of subsections (b) and (c) filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).
3. Repealer and new section filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2791.9. Use of Real Property Sales Contracts.

If a subdivider proposes to sell subdivision interests using real property sales contracts (hereafter sales contracts) as defined in Section 10029 of the Code, a plan under which the subdivider conveys the subdivision interests in trust and records the conveyance prior to the execution of a sales contract by a prospective purchaser (hereafter vendee) and which includes all of the following elements shall be an acceptable alternative method under Section 11013.2(d) and Section 11013.4(f) of the Code:

(a) The original trustee and any successor trustee are expressly subject to the approval of the commissioner.

(b) An express prohibition against any amendment of the trust instrument directly or indirectly affecting the interests of a vendee without the prior written approval of the commissioner.

(c) An agreement by the trustee to continue in that capacity until a successor trustee acceptable to the commissioner has assumed the position.

(d) Vendees are expressly designated in the trust instrument as beneficiaries.

(e) If the subdivision interests in the trust are not subject to a blanket encumbrance, provisions for the vendee to make payments under the contract (hereafter purchase money) to the trustee and for the trustee to make disbursements from purchase money as follows:

(1) Debt service, taxes, assessments, insurance premiums and any other periodic payments related to the ownership and use of the subdivision interest that the vendee is obligated to make under terms of the sales contract.

(2) Payment to the subdivider from the balance of purchase money remaining after the trustee has paid or set aside funds to make payments under (1) above.

(f) If a subdivision interest is subject to a blanket encumbrance as defined in Section 11013 of the Code:

(1) Unless there has been an independent determination that the vendee is in default under the terms of the sales contract, all of the purchase money of a vendee will be held by the trustee in an interest–bearing account for the benefit of the vendee until the subdivision interest that the vendee has contracted to purchase is released from the blanket encumbrance.

(2) Unless there has been an independent determination that the vendee is in default under the terms of the sales contract, the refund on demand by the vendee of the entire sum of purchase money paid if the subdivision interest has not been released from the blanket encumbrance within a specified period of time determined by the commissioner to be reasonable in the circumstances.

(3) If the subdivider proposes a disbursement of purchase money to himself or for his account based upon vendee's default under the sales contract, a procedure for a determination of default by a court of law or arbitrator and for the disbursement by the trustee of funds as liquidated damages on the basis of the determination that the vendee has defaulted.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.2, 11013.4, 11018 and 11018.5, Business and Professions Code.

HISTORY

1. New section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2792. Substantially Complete Application—Standard Subdivision.

An application for a final subdivision public report is "substantially complete" within the meaning of Section 11010.2 of the Code if it contains the documents and information enumerated below:

(a) For a subdivision (standard subdivision) of a type not listed or referred to in Section 11000.1, or 11004.5 of the Code:

(1) Subdivision filing fee including fee for a preliminary public report if applicable.

(2) Completed subdivision questionnaire.

(3) Approved tentative subdivision map unless the Commissioner has made a finding that because of processing delays, a tentative subdivision map has not been approved but will be approved within a reasonable amount of time.

(4) Certificate of qualification from Secretary of State if applicant is a foreign corporation.

(5) Consent to service of process upon Secretary of State if applicant is a nonresident of California.

(6) Current preliminary title report covering all subdivision interests for which a public report is sought including:

(A) Legal description of the subdivided property.

(B) Nature of the interest or estate covered by the report.

(C) Record owner of the interest or estate covered by the report.

(D) All easements, liens, rights, interest and claims disclosed by an examination of the indices in the office of the recorder of the county in which the property is located.

(E) Existence of any encroachment of improvements over lines of record title.

(F) All mechanics liens arising out of work completed or in progress.

(G) Existence of assessments or potential assessments for public improvements completed or under construction.

(7) Proposed or existing covenants, conditions and restrictions for the subdivision.

(8) Coastal Commission permit or exemption if subdivision in coastal zone.

(9) Evidence of availability of domestic utilities and services to the subdivision.

(10) Information concerning hazards and other unusual conditions within or in the vicinity of the subdivision.

(11) Assessment and improvement bond information if applicable to the subdivision interests to be offered.

(12) Exemplars of all marketing, financing and conveyancing instruments to be used in the offering of subdivision interests.

(13) Exemplar of escrow instructions including at least the following:

(A) A description of the nature of the transaction.

(B) Provision for the return to nondefaulting buyers of funds deposited toward the purchase of subdivision interests if escrows are not closed on or before a date prescribed in the instructions.

(C) Name and address of the escrow depository to be used.

(14) Bond or other device to be used as a means of compliance with Sections 11013.2 and 11013.4 of the Code.

(15) Completed documents for reservations and reservation deposits if preliminary public report is requested.

(16) Evidence of financial arrangements to assure completion of all offsite improvements included in the offering.

(17) Evidence of financial arrangements for any guarantee or warranty included in the offering.

(18) Evidence of all arrangements to assure completion, maintenance and availability for any use of privately–owned facility that will be offered as an inducement to the purchase of subdivision interests.

NOTE: Authority cited: Sections 11001 and 11010.2, Business and Professions Code. Reference: Section 11010.2, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49). For history of former section, see Register 63, No. 14.
2. Repealer of subsection (a)(17), subsection renumbering, and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
3. Repealer of subsections (a)(1) and (a)(2), subsection renumbering, and amendment of NOTE filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
4. Amendment of subsection (a)(5) and repealer of subsections (b)–(b)(6) filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
5. Amendment of subsection (a) filed 10–26–99; operative 11–25–99 (Register 99, No. 44).
6. Amendment of subsection (a)(3) filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).

§ 2792.1. Substantially Complete Application—Condominium, Planned Development, Community Apartment Project and Undivided Interest Subdivision.

An application for a final subdivision public report is "substantially complete" within the meaning of Section 11010.2 of the Code if it contains the documents and information enumerated below:

(a) For a condominium project, community apartment project or planned development:

(1) All of the applicable documents and information listed under subdivision (a) of Section 2792.

(2) Proposed or existing governing instruments for the owners' association.

(3) Condominium plan if the subdivision is a condominium.

(4) Plot plan delineating all improvements including recreational amenities if the subdivision is not a condominium.

(5) Overall subdivision plan if the subdivision is part of a phased development.

(6) Evidence of financial arrangements for completion of the common areas and facilities in the offering.

(7) Copies of all contracts or proposed contracts obligating the owners' association.

(8) Agreement of subdivider to subsidize common area maintenance and owners' association operation where applicable.

(9) Financial arrangements to assure performance of the subdivision agreement where applicable.

(10) Detailed pro forma budget reflecting estimated costs of ownership, operation and maintenance expenses and reserves for the subdivision.

(11) Most recent balance sheet and annual operating statement for the owners' association if applicable.

(12) Duplicate budget package for departmental analysis of proposed budget for common area maintenance and owners' association operations.

(13) Subdivision trust agreement if applicable.

(14) Exemplar of deed for conveyance of common area to owners' association.

(15) Exemplar of escrow instructions including at least the following:

(A) A description of the nature of the transaction.

(B) Provision for the return to Buyers of funds deposited toward the purchase of subdivision interests if escrows are not closed on or before a date prescribed in the instructions.

(C) Name and address of the escrow depository to be used.

(D) Provision to assure compliance with subdivision (c) of Section 11018.5 of the Code if applicable.

(E) Provision for conveyance of common area to owners' association if applicable.

(16) A completed supplemental questionnaire if the project is a conversion of an existing structure to a condominium or community apartment project.

(17) A permit issued by the Department of Corporations if applicable to the offering.

(b) For an undivided interest subdivision:

(1) All of the applicable documents and information listed in subdivision (a) above.

(2) A proposed schedule of undivided interests in the subdivision sufficient to identify the undivided interest acquired by each purchaser.

(3) Statement from the appropriate authority of the county in which the real property is located setting forth the proposed method to be used in assessing and collecting real property taxes for the subdivision.

NOTE: Authority cited: Sections 11001 and 11010.2, Business and Professions Code. Reference: Section 11010.2, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49). For history of former section, see Registers 71, No. 50; 65, No. 17; and 63, No. 14.
2. Amendment of subsection (a), repealer of former subsections (b)–(b)(6) and (c)(2), subsection relettering and renumbering, and amendment of NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2792.2. Substantially Complete Application—Stock Cooperative and Limited Equity Housing Cooperative.

An application for a final subdivision public report is "substantially complete" within the meaning of Section 11010.2 of the Code if it contains the documents and information enumerated below:

(a) For a stock cooperative subdivision:

(1) Subdivision filing fee including fee for preliminary public report if applicable.

(2) Completed subdivision questionnaire.

(3) Approved tentative subdivision map if applicable.

(4) Plot plan delineating apartments within the subdivision.

(5) Certificate of qualification from Secretary of State if applicant is a foreign corporation.

(6) Consent to service of process upon Secretary of State if applicant is a nonresident of California.

(7) Current preliminary title report covering all subdivision interests for which a public report is sought including:

(A) Legal description of the subdivided property.

(B) Nature of the interest or estate covered by the report.

(C) Record owner of the interest or estate covered by the report.

(D) All easements, liens, rights, interests and claims disclosed by an examination of the indices in the office of the recorder of the county in which the property is located.

(E) Existence of any encroachment of improvements over lines of record title.

(F) All mechanics liens arising out of work completed or in progress.

(G) Existence of assessments or potential assessments for public improvements completed or under construction.

(8) Proposed or recorded covenants, conditions and restrictions for the subdivision, if applicable.

(9) Coastal Commission permit or exemption if subdivision is in coastal zone.

(10) Evidence of availability of domestic utilities and services to the subdivision.

(11) Information concerning hazards and other unusual conditions within or in the vicinity of the subdivision.

(12) Assessment and improvement bond information if applicable to the subdivision interests to be offered.

(13) Exemplars of all marketing, financing and conveyancing instruments to be used in the offering of subdivision interests.

(14) Exemplar of escrow instructions for conveyance of the subdivision to the cooperative corporation.

(15) Exemplar of escrow instructions for issuance of memberships and exclusive occupancy rights to purchasers including at least the following:

(A) A description of the nature of the transaction.

(B) Provision for the return to Buyers of funds deposited toward the purchase of memberships if escrows are not closed on or before a date prescribed in the instructions.

(C) Name and address of the escrow depository to be used.

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(D) Provision to assure compliance with subdivision (c) of Section 11018.5 of the Code if applicable.

(16) Bond or other device to be used as a means of compliance with Sections 11013.2 and 11013.4 of the Code.

(17) Narrative explanation of plan for financing sales of memberships in cooperative corporation.

(18) Subordination agreement or other instrument to assure compliance with subdivision (c) of Section 11018.5 of the Code.

(19) Completed documents for reservations and reservation deposits if a preliminary public report is requested.

(20) Evidence of financial arrangements to assure completion or proposed renovation of offsite improvements included in the offering.

(21) Evidence of financial arrangements for completion or renovation of common areas of the subdivision.

(22) Evidence of financial arrangements for any guarantee or warranty included in the offering.

(23) Proposed articles of incorporation for cooperative corporation.

(24) Proposed bylaws for cooperative corporation.

(25) Proposed proprietary lease (exclusive occupancy) agreement and proposed lease assignment instrument if applicable.

(26) Copies of all contracts or proposed contracts obligating the cooperative corporation.

(27) Proposed preclosing rental agreements if applicable.

(28) Completed supplemental questionnaire if the subdivision is a conversion of an existing structure to a subdivision.

(29) Detailed pro forma budget reflecting estimated costs of ownership, operation and maintenance expenses and reserves for the subdivision.

(30) Most recent balance sheet and annual operating statement for the cooperative corporation if applicable.

(31) Agreement of subdivider to subsidize common-area maintenance and cooperative corporation operations if applicable.

(32) Duplicate budget package for departmental analysis of proposed budget for common area maintenance and owners association operations.

(33) Proposed schedule for allocation of assessments for property taxes and corporate debt service (if applicable) to members of the corporation.

(34) Exemplar of deed for conveyance of subdivision to cooperative corporation.

(35) Exemplar of membership certificate or stock certificate to be issued by cooperative corporation.

(36) A permit issued by the Department of Corporations if applicable to the offering.

(b) For a limited equity housing cooperative:

(1) All of the applicable documents and information listed in subdivision (a) above.

(2) Information concerning the selling prices and methods for determination of transfer value referred to in Section 33007.5 of the Health and Safety Code.

NOTE: Authority cited: Sections 11001 and 11010.2, Business and Professions Code. Reference: Section 11010.2, Business and Professions Code.

HISTORY

1. New section filed 12-3-80; effective thirtieth day thereafter (Register 80, No. 49). For history of former section, see Registers 71, No. 50; 65, No. 17; 63, No. 14; and 55, No. 5.
2. Repealer of subsection (a)(21), subsection renumbering, and amendment of NOTE filed 11-13-96; operative 11-13-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
3. Repealer of subsections (a)(2) and (a)(3), subsection renumbering, and amendment of NOTE filed 11-27-96; operative 12-27-96 (Register 96, No. 48).

§ 2792.3. Approved Form of Bond for Completion of Common Facilities.

A bond posted pursuant to Section 11018.5(a)(2)(A) to secure the faithful performance of a commitment by the subdivider to complete common facilities and common-area improvements shall be in substantially the following form:

COMPANY NAME

Bond No._____

Premium: $_____

KNOW ALL MEN BY THESE PRESENTS, that we, _____ (Name of subdivider), as PRINCIPAL, and _____ (Name of surety), a corporation organized under the law of the State of _____, and authorized to transact the business of surety in the State of California, as SURETY, are firmly held and bound unto _____ (Name of homeowners association) (hereinafter referred to as OBLIGEE) in the penal sum of _____ Dollars ($_____) for which sum, well and truly to be paid, we bind ourselves, our heirs, administrators, successors and assigns, jointly and severally, firmly by these presents.

This bond is given pursuant to Section 11018.5(a)(2)(A) of the California Business and Professions Code to assure lien-free completion of the improvements described in PRINCIPAL's "Planned Construction Statement," a copy of which is attached hereto and incorporated herein by reference, for the subdivision development known as _____ (Name of subdivision), situated in the County of _____, State of _____.

SURETY, for value received, hereby agrees that the matters set forth in California Civil Code Section 3225, or similar acts or omissions which might release the SURETY pursuant to law, shall not in any way release SURETY from the obligation of this bond or reduce SURETY's obligation thereunder.

SURETY, for value received, does hereby waive the right granted to SURETY under California Civil Code Section 2845 to require that OBLIGEE proceed independently against PRINCIPAL to enforce this obligation, but reserves to itself any right under said Section 2845 to require that OBLIGEE proceed jointly against PRINCIPAL and SURETY in any such actions.

The condition of this obligation is such that if PRINCIPAL shall complete or cause to be completed said improvements free of liens and claims on or before the latest completion date specified in said "Planned Construction Statement," or an extension thereof given in writing by OBLIGEE to PRINCIPAL and assented to in writing by SURETY, then this obligation shall be null and void; otherwise, it shall remain in full force and effect.

A suit or action on this bond must be filed within two years after the latest completion date set forth in the "Planned Construction Statement" or any extension thereof given in writing by OBLIGEE to PRINCIPAL and assented to in writing by SURETY.

The terms, conditions and coverage of this bond have been approved by the Real Estate Commissioner of the State of California.

IN WITNESS WHEREOF, PRINCIPAL and SURETY have caused these presents to be duly signed and sealed this ____ day of _____, 19___

_____ (PRINCIPAL)
By_____

_____ (SURETY)
By_____

NOTE: Authority cited: Sections 10080, 10226, 10149.2, 11001, and 11011.8, Business and Professions Code and Section 21082, Public Resources Code.

HISTORY

1. New section filed 12-2-74; effective thirtieth day thereafter (Register 74, No. 49). For history of former section, see Register 65, No. 17.

§ 2792.4. Special Provision for Enforcement of Bonded Obligations.

When common-area improvements which are included in the subdivision offering have not been completed prior to the issuance of the public report and the subdivision owners' association (hereafter Association) is obligee under a bond or other arrangement (hereafter Bond) to secure performance of the commitment of the subdivider to complete the improvements, the covenants, conditions and restrictions for the subdivision shall include at least the following substantive and procedural provisions relative to the initiation of action to enforce the obligations of the subdivider and the surety under the Bond:

(1) The governing body of the Association shall be directed to consider and vote on the question of action by the Association to enforce the obligations under the Bond with respect to any improvement for which a Notice of Completion has not been filed within 60 days after the completion date specified for that improvement in the Planned Construction Statement appended to the Bond. If the Association has given an extension in writing for the completion of any common–area improvement, the governing body shall be directed to consider and vote on the aforesaid question if a Notice of Completion has not been filed within 30 days after the expiration of the extension.

(2) A special meeting of members for the purpose of voting to override a decision by the governing body not to initiate action to enforce the obligations under the Bond or on the failure of the governing body to consider and vote on the question. The meeting shall be required to be held not less than 35 days nor more than 45 days after receipt by the governing body of a petition for such a meeting signed by members representing 5% or more of the total voting power of the Association.

(3) A vote by members of the Association other than the subdivider at the special meeting called for the purpose set forth in (2) above.

(4) A vote of a majority of the voting power of the Association residing in members other than the subdivider to take action to enforce the obligations under the Board shall be deemed to be the decision of the Association and the governing body shall thereafter implement this decision by initiating and pursuing appropriate action in the name of the Association.

NOTE: Authority cited: Sections 10080, 10226, 10149.2, 11001, and 11011.8, Business and Professions Code, and Sections 21082, Public Resources Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49). For history of former section, see Register 65, No. 17.
2. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).

§ 2792.5. Requirements When Improvement District Is Utilized.

NOTE: Authority cited: Sections 10080, 10249.2 and 11001, Business and Professions Code.

HISTORY

1. New section filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14). For history of former section see Register 55, No. 14.
2. Amendment filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
3. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.6. Required Documents for Condominium and Planned Development Public Report Application.

NOTE: Authority cited: Sections 11001, 11010.2, Business and Professions Code. Reference: Sections 11010.2 (Ch. 1152, Statutes of 1980, AB 2320), Business and Professions Code.

HISTORY

1. Repealer and new section filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7). For prior history, see Register 71, No. 50
2. Amendment filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3).
3. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
4. Repealer filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2792.7. Statement of Maintenance and Operational Costs in Connection with Condominium, Planned Development or Community Apartment.

HISTORY

1. New section filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Amendment filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
3. Repealer filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50).

§ 2792.8. Governing Instruments for Common Interest Subdivisions.

(a) Governing instruments for the ownership and management of subdivisions enumerated in Section 11004.5 of the Code (common–interest subdivisions) including the Covenants, Conditions and Restrictions (CC&Rs), Articles of Incorporation (Articles) and Bylaws shall ordinarily provide for, but need not be limited to, the following:

(1) Creation of an organization (hereafter Association) of subdivision interest owners;

(2) A description of the common interests of the subdivision owners or lessees;

(3) Transfer of title and/or control of common interests or of mutual and reciprocal rights of use to the owners in common or to the Association;

(4) Procedures for calculating and collecting regular assessments from owners to defray expenses attributable to the ownership, operation or furnishing of common interests or to the enjoyment of mutual and reciprocal rights of use;

(5) Procedures for establishing and collecting special assessments for capital improvements or for other purposes;

(6) Liens upon privately–owned subdivision interests for assessments levied pursuant to the CC&Rs and foreclosure thereof for nonpayment;

(7) Policies and Procedures relating to the disciplining of members for failure to comply with provisions of the governing instruments;

(8) Creation of a governing body for the Association;

(9) Procedures for the election and removal of governing body members and officers of the Association;

(10) Enumeration of the powers and duties of the governing body and the officers and of the limitations upon the authority of the governing body to act without the prior approval of members representing a majority of the voting power of the Association;

(11) Allocation of voting rights to Association members;

(12) Preparation of the budgets and financial statements of the Association and for distribution to the Association members;

(13) Regular and special meetings of Association members with notice requirements;

(14) Regular meetings of the governing body with provision for notice to Association members;

(15) Quorum requirements for meetings of members of the Association and of the governing body;

(16) Procedures for proxy voting at members' meetings;

(17) Policies and procedures governing the inspection of books and records of the Association by members;

(18) Amendment procedures for those provisions of the governing instruments which relate to the ownership, management and control of the Association and/or the common interests;

(19) Prohibitions against or restrictions upon the severability of a separately–owned portion from the common interest portion of a subdivision interest;

(20) Conditions upon which a partition of a condominium project may be had pursuant to Section 1359 of the Civil Code;

(21) Action to be taken and procedures to be followed in the event of condemnation, destruction or extensive damage to the subdivision interests, including provisions respecting the use and disposition of insurance proceeds or damages payable to the Association or to a trustee on behalf of owners on account of condemnation, destruction or damage;

(22) Annexation of additional land to the existing development where appropriate;

(23) Architectural and/or design control;

(24) Special provisions for enforcement of financial arrangements by the subdivider to secure performance of his commitment to complete common–area improvements;

(25) Granting of easements or use rights affecting the common areas;

(26) Special provisions authorizing the governing body, subject to compliance with Section 1354 of the Civil Code, to institute, defend,

settle or intervene on behalf of the Association in litigation, arbitration, mediation, or administrative proceedings in matters pertaining to (A) enforcement of the governing instruments, (B) damage to the common areas, (C) damage to the separate interests which the Association is obligated to maintain or repair, or (D) damage to the separate interests which arises out of, or is integrally related to, damage to the common areas or separate interests that the association is obligated to maintain or repair.

(b) The Commissioner will ordinarily consider provisions of the governing instruments proposed for a common-interest subdivision to constitute "reasonable arrangements" under Section 11018.5 of the Code if the provisions are in substantial conformance to the applicable standards prescribed in Sections 2792.4, 2792.15 through 2792.21, 2792.23, 2792.24 and 2792.26 through 2792.28 of these Regulations and if they do not otherwise arbitrarily deny, limit or abridge the right of owners with respect to management, maintenance, preservation, operation or control of their subdivision interests.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11004.5, 11018 and 11018.5, Business and Professions Code.

HISTORY

1. Amendment of subsections (a)(6), (7) and (20) filed 1-16-79; effective thirtieth day thereafter (Register 79, No. 3). For prior history, see Register 76, No. 3.
2. Amendment of subsection (b) filed 1-17-80; effective thirtieth day thereafter (Register 80, No. 3).
3. Amendment of subsection (a)(20) filed 4-2-86; effective thirtieth day thereafter (Register 86, No. 14).
4. Amendment of subsections (a) and (a)(25), new subsection (a)(26) and amendment of NOTE filed 12-7-94; operative 1-6-95 (Register 94, No. 49).
5. Amendment of subsection (b) filed 12-30-97; operative 1-29-98 (Register 98, No. 1).

§ 2792.9. Assuring Operating and Maintenance Fund for Common Facilities and Services.

(a) To assure the availability of funds, or sources of funds, to defray the costs of common facilities and services during the early stages of ownership and operation by the Association and to assure the fulfillment of the subdivider's obligation to pay assessments as an owner of subdivision interests, the Commissioner will ordinarily require that:

(1) No sale of a subdivision interest be closed until 80% of all subdivision interests covered by the final subdivision public report have been conveyed (or leased if that is the marketing plan) and are simultaneously closed; or

(2) The subdivider furnish funds, a surety bond to the Association as obligee, or other security convertible to cash by the escrow depository to assure the fulfillment of the subdivider's obligations as an owner of separate interests covered by the final subdivision public report to pay regular and special assessments; or

(3) The subdivider present an alternative arrangement satisfactory to the Commissioner to secure the fulfillment of the subdivider's obligations to the Association as an owner of separate interests covered by the final subdivision public report.

(b) The security referred to in (a)(2) or (a)(3) above shall ordinarily:

(1) Be in an amount which is equal to six (6) months' regular assessments for the separate interests covered by the final subdivision public report.

(2) Be subject to terms, and conditions which will assure that the subdivider pays, as and when due, all regular and special assessments which are levied by the Association against separate interests owned by the subdivider in the subdivision until title to 80% of the separate interests which are covered by the final subdivision public report have been conveyed (or leased if that is the marketing plan).

(3) Be the subject of a contract signed on behalf of the subdivider and the Association covering release and enforcement of the security.

(4) Be delivered to a neutral escrow depository acceptable to the Commissioner along with instructions to the depository signed on behalf of the subdivider and the Association covering handling of the security, return of the security to the subdivider, and remittance of the security to the Association, including the following:

(A) The escrow instructions shall include a procedure under which the security shall be returned to the subdivider upon the Association's failure to give the escrow depository within 40 days the Association's written objection to return of the security. The return of the security shall be made but only if the subdivider's demand for return of the security is accompanied by the subdivider's written statement that the subdivider has paid, as and when due, all regular and special assessments which have been levied by the Association against separate interests which are covered by the final subdivision public report owned by the subdivider. Before the security shall be returned, the subdivider shall certify that title to 80% of the separate interests which are covered by the final subdivision public report have been conveyed (or leased if that is the marketing plan).

(B) The escrow instructions shall include a procedure under which all or some specified portion of the security shall be remitted to the Association upon the subdivider's failure to give the escrow depository within 40 days the subdivider's written objection to remittance of the security, but only if the Association's demand for remittance of all or some specified portion of the security is accompanied by a written statement signed by an officer of the Association that the subdivider is delinquent in the payment of regular or special assessments which have been levied by the Association against separate interests covered by the final subdivision public report owned by the subdivider.

(C) The escrow instructions shall provide that, in the event the escrow depository receives conflicting instructions from the subdivider and the Association, the escrow holder is authorized, in its sole discretion, to (1) interplead the security or (2) retain the security until the security is disposed of in accordance with (i) the joint or mutual instructions of the subdivider and the Association, (ii) the order of a court of competent jurisdiction or (iii) in accordance with the final binding decision rendered in an alternative dispute resolution proceeding.

(D) If the security is a letter of credit, the escrow instructions shall include a procedure under which the escrow depository shall draw upon the letter of credit prior to the expiration of the time for drawing thereupon, or upon the subdivider's failure to give the escrow depository within 40 days the subdivider's written objection to remittance of the security to the Association.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 8-21-63; designated effective 9-20-63 (Register 63, No. 14).
2. Repealer and new section filed 9-17-65; effective thirtieth day thereafter (Register 65, No. 17).
3. Amendment filed 12-10-71; effective thirtieth day thereafter (Register 71, No. 50).
4. Amendment filed 1-16-76; effective thirtieth day thereafter (Register 76, No. 3).
5. Amendment of subdivision (b) filed 7-1-83; effective thirtieth day thereafter (Register 83, No. 30).
6. Amendment of subsections (a)(1)-(b), repealer of subsections (b)(1) and (b)(2), and new subsections (b)(1)-(b)(4)(D) filed 12-30-97; operative 1-29-98 (Register 98, No. 1).

§ 2792.10. Subsidization by Subdivider.

(a) When the subdivider undertakes to provide goods and/or services to the Association or to pay a portion of a purchaser's share of the Association's financial obligations, the subdivider shall:

(1) Enter into a contract with the Association acceptable in form and content to the Commissioner which shall specify in detail the obligations which the subdivider will undertake to fulfill and, if applicable, the methods to be employed in valuing the goods and services furnished under the program, and cover the release and enforcement of the security referred to in (a)(4), below.

(2) Furnish the Association with an executed copy of the contract, the security referred to in (a)(4), below, and the escrow instructions referred to in (c), below, within ten days after the closing of the first sale (or lease) of subdivision interests.

(3) Submit a monthly accounting to the Association and if the subsidy is other than cash, it shall also contain a description and valuation of the

goods and services for the common area furnished directly by the subdivider or contracted and paid for by him.

(4) Furnish a bond to the Association as obligee or other device to secure the subdivider's undertaking to the Association and the owners under the program. The bond or other device shall be in an amount and subject to terms and conditions which will assure prompt and faithful performance of the contract. The penal sum of a bond shall not ordinarily be reduced by reason of the fact that the subdivider has posted a bond or other security device pursuant to Section 2792.9 of these regulations.

(b) The Commissioner will not ordinarily approve any program in which the subdivider undertakes to provide goods and/or services to the Association or promises to pay a portion of a purchaser's share of the Association's financial obligations unless it provides for the accumulation by the Association of reserves for replacement and major maintenance in accordance with accepted property management practices.

(c) The security device referred to in (a)(4) above shall be delivered to a neutral escrow depository acceptable to the Commissioner along with an executed copy of the contract and instructions to the depositary signed by the subdivider and the Association covering handling of the security, return of the security to the subdivider, and remittance of the security to the Association, including the following:

(1) The escrow instructions shall include a procedure under which the security shall be returned to the subdivider upon the Association's failure to give the escrow depository within 40 days the Association's written objection to return of the security, but only if the subdivider's demand for return of the security is accompanied by the subdivider's written statement that the subdivider has faithfully performed all of the subdivider's obligations under the contract.

(2) The escrow instructions shall include a procedure under which all or some specified portion of the security shall be paid to the Association upon the subdivider's failure to give the escrow depository within 40 days the subdivider's written objection to payment of the security, but only if the Association's demand for payment of the security is accompanied by the Association's written statement that the subdivider has failed to perform the subdivider's obligations under the contract.

(3) The escrow instructions shall provide that, in the event the escrow holder receives conflicting instructions from the subdivider and the Association, the escrow holder is authorized, in its sole discretion, to (1) interplead the security or (2) retain the security until the security is disposed of in accordance with (i) the joint or mutual instructions of the subdivider and the Association, (ii) the order of a court of competent jurisdiction or (iii) in accordance with the final binding decision rendered in an alternative dispute resolution proceeding.

(4) If the security is a letter of credit, the escrow instructions shall include a procedure under which the escrow depository shall draw upon the letter of credit prior to the expiration of the time for drawing thereupon, or upon the subdivider's failure to give the escrow depository within 40 days the subdivider's written objection to remittance of the security to the Association.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer and new section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3). For prior history, see Register 66, No. 25.
2. Amendment of section and NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2792.11. Subdivider's Obligation to Pay Assessments—Record Maintenance.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code; and *PJNR, Inc.* v. *Department of Real Estate* (1991) 230 C.A.3d 1176.

HISTORY

1. New section filed 9–29–92; operative 10–30–92 (Register 92, No. 40). For prior history see Register 80, No. 49.
2. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.12. Undivided Interests Subdivisions—Conveyance of the Property.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11000.1, Business and Professions Code.

HISTORY

1. New section filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
2. Repealer and new section filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50).
3. Repealer of section and new NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.13. Undivided Interests Subdivisions—Impound of Funds.

All funds received from prospective buyers to be applied to the purchase of undivided subdivision interests, including community apartment projects and stock cooperatives and limited equity housing cooperatives, shall be deposited and held intact in an escrow depository acceptable to the Real Estate Commissioner until bona fide offers have been obtained for the purchase of a prescribed percentage of all of the interests being offered for sale.

In the event that the prescribed percentage of offers have not been obtained within two years from the date of the issuance of the public report, or such other period as the commissioner may approve, all funds theretofore collected shall be promptly returned by the escrow depository to owners without deduction.

The prescribed percentage shall be determined by the commissioner based upon the facts and circumstances of each such offering. Ordinarily this percentage shall be not less than 60% of the interests being offered for sale provided, however, that the commissioner may prescribe a lesser percentage if the plan of the offering includes other financial arrangements to lessen the possibility of foreclosure of a non–delinquent interest on account of the delinquencies of other owners.

HISTORY

1. New section filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
2. Amendment filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50).
3. Amendment filed 6–30–80; effective thirtieth day thereafter (Register 80, No. 28).

§ 2792.14. Undivided Interests Subdivisions—Blanket Encumbrances.

(a) Except as provided in subdivision (b) hereof, if the real property to be owned by the stock cooperative corporation will be subject to a mortgage or deed of trust affecting the interest of more than one member or shareholder of the stock cooperative (hereafter blanket encumbrance), a public report will not be issued unless legal or financial arrangements satisfactory to the Real Estate Commissioner have been made to:

(1) Provide assurance that the ownership and possessory rights of a member of the stock cooperative will not be adversely affected by foreclosure or acceleration of the blanket encumbrance by or on behalf of the beneficiary unless the affected member or shareholder is delinquent in payments allocated by the stock cooperative to debt service on the blanket encumbrance.

(2) Provide assurance for the payment of said blanket encumbrance.

(b) The provisions of subdivision (a) shall not apply in the case of a stock cooperative which is

(1) insured under section 213 or section 221 of the National Housing Act, as amended and involves a regulatory agreement between stock cooperative and the Secretary of Housing and Urban Development with the provision for the establishment and maintenance of a general operating reserve or

(2) assisted under section 8 of the U. S. Housing Act of 1937 as amended and involves a housing assistance payment contract between the stock cooperative and the Secretary of Housing and Urban Development with a special provision for the establishment and maintenance of a general operating reserve as the Secretary of Housing and Urban Development may approve.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013, 11013.1, 11013.2, 11013.4, Business and Professions Code.

HISTORY

1. New section filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
2. Repealer and new section filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. Amendment of section (a) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).

§ 2792.15. Reasonable Arrangements—Transfer of Common Areas and Facilities to Association.

(a) In subdivisions in which all or a portion of the common areas and facilities are to be transferred to the Association, those areas and facilities shall be transferred to the Association or to a corporate trustee under a trust agreement acceptable to the Commissioner prior to or coincident with the first transfer or conveyance of a subdivision interest by the subdivider.

(b) The subdivider may create a contractual right in himself or may reserve easements of limited duration, for common driveway purposes, for drainage and encroachment purposes and for ingress to and egress from the common areas for the purpose of completing improvements thereon or for the performance of necessary repair work and, in the case of phased subdivision projects, for entry onto adjacent property in connection with the development of additional phases of the overall project.

NOTE: Authority cited: Sections 10080, 10226, 11001, 11011.8, Business and Professions Code, and Section 21082, Public Resources Code.

HISTORY

1. New section filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
2. Repealer and new section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).

§ 2792.16. Reasonable Arrangements—Assessments and Liens.

(a) Regular assessments to defray expenses attributable to the ownership, operation and furnishing of common interests by the Association shall ordinarily be levied against each owner according to the ratio of the number of subdivision interests owned by the owner assessed to the total number of interests subject to assessments.

(b) In the case of a subdivision offering in which it is reasonable to anticipate that any owner will derive as much as 10% more than any other owner in the value of common services supplied by the Association, the assessment against each owner may be determined according to a formula or schedule under which the assessments against the various subdivision interests bear a relationship which is equitably proportionate to the value of the common services furnished to the respective interests.

(c) The subdivider—and his successor in interest, if any—is an owner subject to the payment of regular and special assessments against subdivision interests which he owns provided, however, that the subdivider and any other owner of a subdivision interest which does not include a structural improvement for human occupancy may be exempted by the governing instruments from the payment of that portion of any assessment which is for the purpose of defraying expenses and reserves directly attributable to the existence and the use of the structural improvement. The exemption may include, but shall not necessarily be limited to:

Roof replacement;

Exterior maintenance;

Walkway and carport lighting;

Refuse disposal;

Cable television; and

Domestic water supplied to living units.

(1) Any exemption from the payment of assessments attributed to dwelling units shall be in effect only until the earliest of the following events.

(A) A notice of completion of the structural improvements has been recorded.

(B) Occupation or use of the dwelling unit.

(C) Completion of all elements of the residential structures which the Association is obliged to maintain.

(2) The subdivider and any other owner of a subdivision interest may be exempted by the governing instruments from the payment of that portion of any assessment which is for the purpose of defraying expenses and reserves directly attributable to the existence and use of a common facility that is not complete at the time assessments commence. Any exemption from the payment of assessments attributed to common facilities shall be in effect only until the earliest of the following events.

(A) A notice of completion of the common facility has been recorded.

(B) The common facility has been placed into use.

(d) The governing body of the Association must comply with the provisions of Section 1366 of the Civil Code prior to any increase in assessments.

(e) (T)he governing body of the Association may not levy special assessments without complying with the provisions of Section 1366 of the Civil Code.

(f)(1) Regular assessments against the subdivision interests in a phase of a multi–phase subdivision or against all subdivision interests in a single–phase subdivision shall commence on the date of the first conveyance of a subdivision interest in that phase under authority of a public report or on the first day of the month following the first conveyance of a subdivision interest in the phase.

(2) Except in those subdivision offerings where there is an approved subsidization plan which otherwise provides, voting rights attributable to subdivision interests shall not vest until assessments against those interests have been levied by the Association.

(g)(1) A lien for regular or special assessments against an owner may be made subordinate by the CC&R's to the lien of any first mortgage or first deed of trust (hereafter collectively first encumbrance) against subdivision interests of the owner.

(2) In the case of a subordination of a lien for assessments to a first encumbrance, the transfer of a subdivision interest as the result of the exercise of a power of sale or a judicial foreclosure involving a default under the first encumbrance shall extinguish the lien of assessments which were due and payable prior to the transfer of the subdivision interest.

(3) No transfer of the subdivision interest as the result of a foreclosure or exercise of a power of sale shall relieve the new owner, whether it be the former beneficiary of the first encumbrance or another person, from liability for any assessments thereafter becoming due or from the lien thereof.

(h)(1) For the purpose of subdivision (d) and subdivision (e), a quorum means more than 50% of the members of the Association.

(2) Any meeting or election of the Association for purposes of complying with subdivision (d) and subdivision (e) shall be conducted in accordance with Chapter 5 (commencing with Section 7510) of Part 3, Division 2 of Title 1 of the Corporations Code and Section 7613 of the Corporations Code.

(i) Notwithstanding any other provision contained in this section, the governing body may increase assessments necessary for emergency situations pursuant to Section 1366 of the Civil Code.

(j) The governing body shall not expend funds designated as reserve funds for any purpose other than those purposes set forth in Section 1365.5 of the Civil Code.

NOTE: Authority cited: Sections 10080, 11001 and 11018.5, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code; and Sections 1365.5 and 1366, Civil Code.

HISTORY

1. New subsection (g) filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3). For prior history, see Register 77, No. 7.
2. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. Amendment of subsection (e) filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
4. Amendment filed 1–11–84; effective thirtieth day thereafter (Register 84, No. 2).
5. Amendment of subsection (c) filed 12–30–86; effective thirtieth day thereafter (Register 87, No. 1).

6. Amendment of subsections (d) and (e) and new subsections (h) and (i) filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
7. Amendment of subsection (d) and new subsections (e)(5) and (j)(1)–(j)(3)(c)4. filed 4–1–93; operative 5–3–93 (Register 93, No. 14).
8. New subsections (d)–(d)(1)(B), subsection renumbering, and amendment of newly designated subsection (d)(2), subsection (d)(3) and NOTE filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
9. Editorial correction of printing error in subsection (d)(2) (Register 94, No. 21).
10. Editorial correction restoring inadvertently omitted subsection (g)(1) (Register 95, No. 21).
11. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.17. Reasonable Arrangements—Members' Meetings.

(a) Regular meetings of members of the Association shall be held not less frequently than once each calendar year at a time and place prescribed by the Bylaws. The first meeting of the Association, whether a regular or special meeting, shall be held within 45 days after the closing of the sale of the subdivision interest which represents the 51st percentile interest authorized for sale under the first public report for the subdivision, provided that public report authorizes the sale of 50 subdivision interests or more in the subdivision. However, but in no event shall the meeting be held later than six months after the closing of the sale of the first subdivision interest without regard to the number of subdivision interests authorized for sale in the first public report.

(b) Meetings of Association members shall be conducted in accordance with the provisions of Section 1363 of the Civil Code.

(c) A special meeting of the members of the Association shall be promptly scheduled by the governing body in response to:

(1) The vote of the governing body itself.

(2) Written request for a special meeting signed by members representing at least 5% of the total voting power of the Association.

(d) Written notice of regular and special meetings shall be given to members by the governing body by any means which is appropriate given the physical setup of the subdivision. This notice shall be given not less than 10 nor more than 90 days before the date of any meeting at which members are required or permitted to take any action. The notice shall specify the place, day and hour of the meeting and the matters the governing body intends to present for action by the members. Except as otherwise provided by law, any proper matter may be presented at the meeting for action.

(e) (1) Except as provided in Sections 2792.16(d) and (e)(1), a quorum for the transaction of business at a meeting of members of the Association through presence in person or by proxy shall be established at a percentage of not less than 25% and not more than 66 2/3% of the total voting power of the Association. Within these percentage limits, the quorum requirements for members' meetings shall be suited to such factors as the proposed physical layout of the subdivision, the contemplated number of owners of subdivision interests and the nature and extent of the common areas, facilities and services.

(2) In the absence of a quorum at a members' meeting a majority of those present in person or by proxy may adjourn the meeting to another time, but may not transact any other business. An adjournment for lack of a quorum by those in attendance shall be to a date not less than five days and not more than 30 days from the original meeting date. The quorum for an adjourned meeting may be set by the governing instruments at a percentage less than that prescribed for the regular meeting, but it shall not be less than 25 percent of the total voting power of the Association. If a time and place for the adjourned meeting is not fixed by those in attendance at the original meeting or if for any reason a new date is fixed for the adjourned meeting after adjournment, notice of the time and place of the adjourned meeting shall be given to members in the manner prescribed for regular meetings.

(f) Any action which may be taken by the vote of members at a regular or special meeting, except the election of governing body members where cumulative voting is a requirement, may be taken without a meeting if done in compliance with the provisions of Section 7513 of the Corporations Code.

(g) Any form of proxy or written ballot distributed by any person to the membership of the Association shall afford the opportunity to specify a choice between approval and disapproval of each matter or group of matters to be acted upon, except it shall not be mandatory that a candidate for election to the governing body be named in the proxy or written ballot. The proxy or written ballot shall provide that, where the member specifies a choice, the vote shall be cast in accordance with that choice. The proxy shall also identify the person or persons authorized to exercise the proxy and the length of time it will be valid.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. Amendment of subsection (c) filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
4. New subsection (g) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
5. Amendment of subsection (e)(1) filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
6. Amendment of subsection (a) filed 4–7–92; operative 5–7–92 (Register 92, No. 14).
7. Amendment of subsections (b) and (d) filed 4–1–93; operative 5–3–93 (Register 93, No. 14).
8. Amendment of subsection (b) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.18. Reasonable Arrangements—Members' Voting Rights.

(a) With the exception of those Associations which have two classes of voting membership, a member of an Association, including an Association which provides for unequal assessments against the subdivision interests, shall be entitled to one vote for each subdivision interest owned. If a subdivision interest is owned by more than one person, each such person shall be a member of the Association, but there shall be no more than one vote for each subdivision interest.

(b) An Association may have two classes of voting membership according to the following provisions:

(1) Each owner of a subdivision interest other than a subdivider is a Class A member. Class A membership entitles the holder to one vote for each subdivision interest owned.

(2) The subdivider is a Class B member. Class B membership entitles the holder to not more than three votes for each subdivision interest owned.

(3) In a single–phase subdivision development, Class B membership shall be irreversibly converted to Class A membership on the first to occur of the following:

(A) The total outstanding votes held by Class A members equal the total outstanding votes held by the Class B member.

(B) A prescribed date which is not later than the second anniversary of the first conveyance of a subdivision interest in the development.

(4) In a multi–phase development for which the subdivider has submitted a plan for phased development through annexation which satisfies the requirements of Section 2792.27, the Class B membership shall be irreversibly converted to Class A membership on the first to occur of the following:

(A) A prescribed date certain which is not later than the second anniversary of the first conveyance of a subdivision interest in the most recent phase of the development.

(B) A prescribed date certain which is not later than the fourth anniversary of the first conveyance of a subdivision interest in the first phase of the development.

(c) With the exception of Section 2792.4, no regulation which requires the approval of a prescribed majority of the voting power of members of the Association other than the subdivider for action to be taken by the Association is intended to preclude the subdivider from casting votes attributable to subdivision interest which he or she owns. Governing instruments may specify either or both of the following for approval of action for which a regulation of the Department—other than Section

2792.4—requires the approval of a prescribed majority of the voting power of members of the Association other than the subdivider:

(1) In those Associations in which Class A and Class B voting memberships have been prescribed in accordance with this regulation, the vote or written assent of a bare majority of the Class B voting power as well as the vote or written assent of a prescribed majority of the Class A voting power.

(2) In those Associations in which a single class of voting membership exists, either as originally established or after the conversion of Class B to Class A shares, the vote or written assent of a bare majority of the total voting power of the Association as well as the vote or written assent of a prescribed majority of the total voting power of members other than the subdivider.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment of subsection (e)(4) filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
4. Amendment filed 1–7–81; effective thirtieth day thereafter (Register 81, No. 2).
5. Amendment of subsections (a) and (b) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
6. Amendment of subsections (b)(3)(B), (b)(4)(A)–(B) and (c) filed 4–7–92; operative 5–7–92 (Register 92, No. 14).
7. Amendment of subsections (b)(3)(B), (4)(A), (4)(B) and NOTE filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2792.19. Reasonable Arrangements—Election of Governing Body.

(a) The first election of a governing body for the Association shall be conducted at the first meeting of the Association. All positions on the governing body shall be filled at that election.

(b) (1) Voting for the governing body shall be by secret written ballot. Cumulative voting in the election of governing body members shall be prescribed for all elections in which more than two positions on the governing body are to be filled subject only to the procedural prerequisites to cumulative voting prescribed in Section 7615(b) of the Corporations Code.

(2) Unless the entire governing body is removed from office by the vote of members of the Association, no individual governing body members shall be removed prior to the expiration of his term of office if the votes cast against removal would be sufficient to elect the governing body member if voted cumulatively at an election at which the same total number of votes were cast and the entire number of governing body members authorized at the time of the most recent election of the governing body member were then being elected.

(c) (1) A special procedure shall be established by the governing instruments to assure that from the first election of the governing body and thereafter for so long as a majority of the voting power of the Association resides in the subdivider, or so long as there are two outstanding classes of membership in the Association, not less than 20% of the incumbents on the governing body shall have been elected solely by the votes of owners other than the subdivider.

(2) A governing body member who has been elected to office solely by the votes of members of the Association other than the subdivider may be removed from office prior to the expiration of his term of office only by the vote of at least a simple majority of the voting power residing in members other than the subdivider.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code and Section 21082, Public Resources Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment of subsection (b)(2) filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
4. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
5. Amendment of subsection (b)(2) and repealer of subsection (d) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.20. Reasonable Arrangements—Governing Body Meetings.

(a) Regular meetings of the governing body of the Association shall be held as prescribed in the Bylaws. Ordinarily such meetings shall be conducted at least monthly though the Bylaws may prescribe meetings as infrequently as every six months if business to be transacted by the governing body does not justify more frequent meetings.

(b)(1) Regular meetings of the governing body shall be held at a time and at a meeting place fixed by the governing body from time to time. The meeting place shall ordinarily be within the subdivision itself unless in the judgment of the governing body a larger meeting room is required than exists within the subdivision in which case the meeting room selected shall be as close as possible to the subdivision.

(2) Notice of the time and place of a regular meeting shall be posted at a prominent place or places within the common area and shall be communicated to governing body members not less than four days prior to the meeting unless the time and place of meeting is fixed by the Bylaws provided, however that notice of a meeting need not be given to any governing body member who has signed a waiver of notice or a written consent to holding of the meeting. If the common area consists only of an easement or is otherwise unsuitable for posting of such notice, the governing body shall communicate the notice of the time and place of such meeting by any means it deems appropriate.

(c)(1) A special meeting of the governing body may be called by written notice signed by the President of the Association or by any two members of the governing body other than the President.

(2) The notice shall specify the time and place of the meeting and the nature of any special business to be considered.

(3) Notice shall be posted or communicated in a manner prescribed for notice of regular meetings and shall be sent to all governing body members not less than 72 hours prior to the scheduled time of the meeting provided however that notice of the meeting need not be given to any governing body member who signed a waiver of notice or a written consent to holding of the meeting.

(d) Regular and special meetings of the governing body shall be governed by the provisions of Section 1363.05 of the Civil Code.

(e)(1) The governing body may take actions without a meeting if all of its members consent in writing to the action to be taken.

(2) If the governing body resolves by unanimous written consent to take action, an explanation of the action taken shall be posted at a prominent place or places within the common area within three days after the written consents of all governing body members have been obtained. If the common area consists only of an easement or is otherwise unsuitable for posting the explanation of the action taken, the governing body shall communicate said explanation by any means it deems appropriate.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
4. New subsection (e) filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
5. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
6. Amendment filed 5–9–90; operative 6–8–90 (Register 90, No. 25).

7. Amendment of subsection (d) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
8. Editorial correction of printing errors in section (Register 91, No. 44).
9. Amendment of subsections (b)(2), (c)(2)–(3) and (e)(2) filed 4–7–92; operative 5–7–92 (Register 92, No. 14).
10. Editorial correction of subsections (c)(2) and (e)(2) (Register 95, No. 13).
11. Redesignation and amendment of former subsection (d)(1) to new subsection (d), repealer of subsection (d)(2), and amendment of subsection (e) filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2792.21. Reasonable Arrangements—Governing Body Powers and Limitations.

(a) The powers and duties of the governing body of the Association shall normally include, but shall not be limited to, the following:

(1) Enforcement of applicable provisions of the Covenants, Conditions and Restrictions, Articles, Bylaws and other instruments for the ownership, management and control of the subdivision.

(2) Payment of taxes and assessments which are, or could become, a lien on the common area or a portion thereof.

(3) Contracting for casualty, liability and other insurance on behalf of the Association.

(4) Contracting for goods and/or services for the common areas, facilities and interests or for the Association subject to the limitations set forth below.

(5) Delegation of its powers to committees, officers or employees of the Association as expressly authorized by the governing instruments.

(6) Preparation of budgets and financial statements for the Association as prescribed in the governing instruments.

(7) Formulation of rules of operation of the common areas and facilities owned or controlled by the Association.

(8) Initiation and execution of disciplinary proceedings against members of the Association for violations of provisions of the governing instruments in accordance with procedures set forth in the governing instruments.

(9) Entering upon any privately–owned subdivision interest as necessary in connection with construction, maintenance or emergency repair for the benefit of the common area or the owners in common.

(10) Election of officers of the governing body.

(11) Filling of vacancies on the governing body except for a vacancy created by the removal of a governing body member.

(b) The governing body of the Association shall ordinarily be prohibited from taking any of the following actions, except with the assent, by vote at a meeting of the Association or by written ballot without a meeting pursuant to Corporations Code Section 7513, of a simple majority of the members, other than the subdivider, constituting a quorum consisting of more than 50 percent of the voting power of the Association residing in members other than the subdivider:

(1) Entering into a contract with a third person wherein the third person will furnish goods or services for the common area or the owners' Association for a term longer than one year with the following exceptions:

(A) A management contract, the terms of which have been approved by the Federal Housing Administration or Veterans Administration.

(B) A contract with a public utility company if the rates charged for the materials or services are regulated by the Public Utilities Commission provided, however, that the term of the contract shall not exceed the shortest term for which the supplier will contract at the regulated rate.

(C) Prepaid casualty and/or liability insurance policies of not to exceed three years duration provided that the policy permits short rate cancellation by the insured.

(D) Lease agreements for laundry room fixtures and equipment of not to exceed five years duration provided that the lessor under the agreement is not an entity in which the subdivider has a direct or indirect ownership interest of 10 percent or more.

(E) Agreements for cable television services and equipment or satellite dish television services and equipment of not to exceed five years duration provided that the supplier is not an entity in which the subdivider has a direct or indirect ownership interest of 10 percent or more.

(F) Agreements for sale or lease of burglar alarm and fire alarm equipment, installation and services of not to exceed five years duration provided that the supplier or suppliers are not entities in which the subdivider has a direct or indirect ownership interest of 10 percent or more.

(G) A contract for a term not to exceed three years that is terminable by the Association after no longer than one year without cause, penalty, or other obligation upon ninety (90) days written notice of termination to the other party.

(2) Incurring aggregate expenditures for capital improvements to the common area in any fiscal year in excess of 5% of the budgeted gross expenses of the Association for that fiscal year.

(3) Selling during any fiscal year property of the Association having an aggregate fair market value greater than 5% of the budgeted gross expenses of the Association for that fiscal year.

(4) Paying compensation to members of the governing body or to officers of the Association for services performed in the conduct of the Association's business provided, however, that the governing body may cause a member or officer to be reimbursed for expenses incurred in carrying on the business of the Association.

(5) In the case of a limited equity housing cooperative, using the corporate equity for any purpose permitted under Section 33007.5(d)(1) of the Health and Safety Code without the vote or written consent of a bare majority of the stock or membership interests of resident owners.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code; and Sections 1354 and 1355, Civil Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. New subsection (b)(6) filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
4. Amendment of subsections (a)(1) and (b)(1) filed 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
5. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
6. New subsection (b)(1)(E) filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
7. Amendment of subsection (b)(1)(E) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
8. New subsection (b)(1)(F) filed 12–30–86; effective thirtieth day thereafter (Register 87, No. 1).
9. Amendment of subsection (b), new subsections (b)(1)(G) and (c)–(d)(2) and amendment of NOTE filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
10. New subsection (e) filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
11. Repealer of subsections (c)–(e) filed 6–15–98; operative 7–15–98 (Register 98, No. 25).

§ 2792.22. Reasonable Arrangements—Budgets and Financial Statements.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code; and Section 1365, Civil Code.

HISTORY

1. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3). For prior history, see Register 76, No. 3.
2. Amendment filed 2–1–84; designated effective 2–10–84 pursuant to Government Code section 11346.2(d) (Register 84, No. 5).
3. Amendment of subsection (a)(1) filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
4. New subsection (d) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
5. Amendment of subsections (a)(1)(C) and (b) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
6. Amendment filed 5–9–90; operative 6–8–90 (Register 90, No. 25).
7. Amendment of subsections (b) and (c) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
8. Editorial correction of printing errors (Register 91, No. 44).
9. Repealer and new subsections (a)(1)(B) and (a)(1)(C) filed 4–1–93; operative 5–3–93 (Register 93, No. 14).

10. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.23. Reasonable Arrangements—Inspection of Association's Books and Records.

(a) Commencing not later than 90 days after the close of escrow of the first interest in the subdivision, copies of the documents listed below, as soon as readily obtainable, shall be delivered by the subdivider to the governing body of the Association at the office of the Association, or at such other place as the governing body of the Association shall prescribe. The obligation to deliver the documents listed below shall apply to any documents obtained by the subdivider no matter when obtained, provided, however, such obligation shall terminate upon the earlier of (1) the conveyance of the last subdivision interest covered by a subdivision public report or (2) three years after the expiration of the most recent public report, on the subdivision:

(1) The recorded subdivision map or maps for the project.

(2) The recorded condominium plan, if any, and all amendments thereto.

(3) The deeds and easements executed by the subdivider conveying the common area or other interest to the Association, to the extent applicable.

(4) The recorded covenants, conditions and restrictions for the subdivision, including all amendments and annexations thereto.

(5) The Association's filed articles of incorporation, if any, and all amendments thereto.

(6) The Association's bylaws and all amendments thereto.

(7) All architectural guidelines and all other rules regulating the use of an owner's interest in the subdivision or use of the common area which have been promulgated by the Association.

(8) The plans approved by the local agency or county where the subdivision is located for the construction or improvement of facilities that the Association is obligated to maintain or repair; provided, however, that the plans need not be as–built plans and that the plans may bear appropriate restrictions on their commercial exploitation or use and may contain appropriate disclaimers regarding their accuracy.

(9) All notice of completion certificates issued for common area improvements (other than residential structures).

(10) Any bond or other security device in which the Association is the beneficiary.

(11) Any written warranty being transferred to the Association for common area equipment, fixtures or improvements.

(12) Any insurance policy procured for the benefit of the Association, its governing board or the common area.

(13) Any lease or contract to which the Association is a party.

(14) The membership register, including mailing addresses and telephone numbers, books of account and minutes of meetings of the members, of the governing body and of committees of the governing body of the Association.

(15) Any instrument referred to in Section 11018.6(d) but not described above which establishes or defines the common, mutual or reciprocal rights or responsibilities of members of the Association.

(b) Commencing not later than 90 days after the annexation of additional phases to the subdivision, copies of those documents listed under subdivision (a) which are applicable to that phase, shall, as soon as readily obtainable, be delivered by the subdivider to the governing body of the Association at the office of the Association, or at such other place as the governing body of the Association shall prescribe. The obligation to deliver the documents listed in subsection (a) shall apply to any documents obtained by the subdivider no matter when obtained, provided, however, such obligation shall terminate upon the earlier of (1) the conveyance of the last subdivision interest covered by a subdivision public report or (2) three years after the expiration of the most recent public report, on the subdivision.

(c) The membership register, including mailing addresses and telephone numbers, books of account and minutes of meetings of the members, of the governing body and of committees of the governing body of the Association shall be made available for inspection and copying by any member of the Association—or by his duly–appointed representative—at any reasonable time and for a purpose reasonably related to his interest as a member, at the office of the Association or at such other place within the subdivision as the governing body shall prescribe.

(d)(1) In the case of the minutes, minutes proposed for adoption that are marked to indicate draft status, or a summary of the minutes, of any meeting of the governing body, other than an executive session, shall be available to members within 30 days of the meeting and shall be distributed to only members upon request and payment of the fee prescribed in (e)(3) below.

(2) At the time the pro forma operating budget is distributed or at the time of any general mailing, members of the Association shall be notified in writing of their right to have copies of the minutes of meetings of the governing body and as to how and where those minutes may be obtained and the cost of obtaining such copies.

(e) The governing body shall establish reasonable rules with respect to:

(1) Notice to be given to the custodian of the records by the member of the Association desiring to make the inspection.

(2) Hours and days of the week when such an inspection may be made.

(3) Payment of the cost of reproducing copies of documents requested by a member of the Association.

(f) Every member of the governing body shall have the absolute right at any reasonable time to inspect all books, records and documents of the Association and the physical properties owned or controlled by the Association. The right of inspection by a member of the governing body includes the right to make extracts and copies of documents.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code; and Section 1363, Civil Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment of NOTE filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of subsection (a) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
4. New subsections (b)(1) and (b)(2) and subsection relettering filed 4–1–93; operative 5–3–93 (Register 93, No. 14).
5. New subsections (a)–(b), subsection redesignation and amendment of subsections (d)(1), (e)(1), (e)(3), (f) and NOTE filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
6. Amendment of subsection (d)(2) and NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2792.24. Reasonable Arrangements—Governing Instruments Amendments.

(a) In a single–class voting structure, amendments of the CC&R's may be enacted by requiring the vote or written assent of members representing both:

(1) A majority of the total voting power of the Association which is at least a bare majority and not more than 75%; and

(2) At least a bare majority of the votes of members other than the subdivider.

The percentage of the voting power necessary to amend a specific clause or provision shall not be less than the percentage of affirmative votes prescribed for action to be taken under that clause. For example, if the CC&R's expressly state that 75% of the voting power must agree to an increase in the maximum annual assessment, then 75% of the voting power is necessary to amend this provision regardless of the percentage prescribed in the general provision pertaining to amendments of the CC&R's.

(b) Amendments of the Articles or Bylaws shall require the vote or written assent of members as follows:

(1) An owners association other than for a limited equity housing cooperative.

(A) Articles

1. At least a bare majority of the governing body; and

2. At least a bare majority of the voting power of the association; and

3. At least a bare majority of the votes of members other than the subdivider.

(B) Bylaws

1. At least a bare majority of a quorum, but not more than a bare majority of the voting power of the association; and

2. At least a bare majority of the votes of members other than the subdivider.

(2) An owners association for a limited equity housing cooperative.

(A) Articles

1. At least a bare majority of the governing body; and

2. At least 66 2/3 percent of the resident–owner members or shareholders.

(B) Bylaws

1. At least 66 2/3 percent of the resident–owner members or shareholders.

(c) Notwithstanding the provisions of (b) above, the percentage of a quorum or of the voting power of the Association or of members other than the subdivider necessary to amend a specific clause or provision in the Articles or Bylaws shall not be less than the prescribed percentage of affirmative votes required for action to be taken under that clause.

(d) If a two–class voting structure is provided and is still in effect in the Association, none of the governing instruments may be amended without the vote or written assent of a prescribed percentage of the voting power of each class of membership or a prescribed percentage of a quorum of members of each class.

(e) If a two–class voting structure was originally provided in the governing instruments, but is no longer in effect because of the conversion of one class to the other, the provisions for amending the governing instruments set forth in subdivisions (a) and (b) above shall be applicable.

NOTE: Authority cited: Sections 10080, 10170.4, and 11001, Business and Professions Code and Section 21082, Public Resources Code. Reference: Sections 11003.2, 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment filed 11–30–77; effective thirtieth day thereafter (Register 77, No. 49).
4. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).

§ 2792.25. Reasonable Arrangements—Restrictions upon Alienation.

NOTE: Authority cited: Sections 10080, 10226, 11001, 11011.8, Business and Professions Code and Section 21082, Public Resources Code. Reference: Sections 11003.2, 11018, 11018.5, Business and Professions Code; and Sections 35700 et seq., Health and Safety Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment and new subsection (c) filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
4. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.26. Reasonable Arrangements—Disciplining of Members by the Association.

(a) The Association cannot be empowered to cause a forfeiture or abridgement of an owner's right to the full use and enjoyment of his individually–owned subdivision interest on account of the failure by the owner to comply with provisions of the governing instruments or of duly–enacted rules of operation for common areas and facilities except by judgment of a court or a decision arising out of an arbitration or on account of a foreclosure or sale under a power of sale for failure of the owner to pay assessments duly levied by the Association.

(b) The governing instruments shall include provisions which authorize the governing body to impose monetary penalties, temporary suspensions of an owner's rights as a member of the Association or other appropriate discipline for failure to comply with the governing instruments provided that the procedures for notice and hearing, satisfying the minimum requirements of subdivision (h) of Section 1363 of the Civil Code, are followed with respect to the accused member before a decision to impose discipline is reached.

(c) A monetary penalty imposed by the Association as a disciplinary measure for failure of a member to comply with the governing instruments or as a means of reimbursing the Association for costs incurred by the Association in the repair of damage to common areas and facilities for which the member was allegedly responsible or in bringing the member and his subdivision interest into compliance with the governing instruments may not be characterized nor treated in the governing instruments as an assessment which may become a lien against the member's subdivision interest enforceable by a sale of the interest in accordance with the provisions of Sections 2924, 2924(b) and 2924(c) of the Civil Code.

(d) The provisions of subdivision (c) do not apply to charges imposed against an owner consisting of reasonable late payment penalties for delinquent assessments and/or charges to reimburse the Association for the loss of interest and for costs reasonably incurred (including attorney's fees) in its efforts to collect delinquent assessments.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Amendment of subsection (b) filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3). For prior history, see Register 76, No. 3.
2. Amendment filed 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
3. Amendment of subsection (b) filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2792.27. Reasonable Arrangements—Annexation of Property to the Subdivision.

(a) Provisions in the CC & Rs to effect the annexation of real property to the existing subdivision shall require the vote or written assent of not less than 66 2/3% of the total votes residing in Association members other than the subdivider unless the proposed annexation is in substantial conformance with a detailed plan of phased development submitted to the commissioner with the application for a public report for the first phase of the subdivision.

(b) The plan for phased development through annexation referred to in subdivision (a) must include, but need not be limited to, the following:

(1) Proof satisfactory to the Commissioner that no proposed annexation will result in an overburdening of common facilities.

(2) Proof satisfactory to the Commissioner that no proposed annexation will cause a substantial increase in assessments against existing owners which was not disclosed in subdivision public reports under which pre–existing owners purchased their interests.

(3) Identification of the land proposed to be annexed and the total number of residential units then contemplated by the subdivider for the overall subdivision development.

(4) A written commitment by the subdivider to pay to the association, concurrently with the closing of the escrow for the first sale of a subdivision interest in an annexed phase, appropriate amounts for reserves for replacement or deferred maintenance of common area improvements in the annexed phase necessitated by or arising out of the use and occupancy of residential units under a rental program conducted by the subdivider which has been in effect for a period of at least one year as of the date of closing of escrow for the first sale of a residential unit in the annexed phase.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).

4. Repealer of subsection (b)(4) and subsection renumbering filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.28. Reasonable Arrangements—Architectural and Design Control.

(a) The committee for the control of structural and landscaping architecture and design (Architectural Control Committee) within the subdivision shall consist of not less than three nor more than five members.

(b) The subdivider may appoint all of the original members of the Architectural Control Committee and all replacements until the first anniversary of the issuance of the original public report for the first (or only) phase of the subdivision. The subdivider may reserve to himself the power to appoint a majority of the members of the Committee until 90% of all the subdivision interests in the overall development have been sold or until the fifth anniversary date of the original issuance of the final public report for the first (or only) phase of the subdivision, whichever first occurs.

(c) After one year from the date of issuance of the original public report for the first (or only) phase of the subdivision, the governing body of the Association shall have the power to appoint one member to the Architectural Control Committee until 90% of all of the subdivision interests in the overall development have been sold or until the fifth anniversary date of the original issuance of the final public report for the first (or only) phase of the subdivision, whichever first occurs. Thereafter the governing body of the Association shall have the power to appoint all of the members of the Architectural Control Committee.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code; and Section 21082, Public Resources Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Redesignation of former subsections (a)(1), (a)(2) and (a)(3) as subsections (a), (b) and (c), respectively, repealer of former subsection (b), and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.29. Reasonable Arrangements—Distribution in the Case of Condemnation or Destruction.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, 11003.2, Business and Professions Code.

HISTORY

1. New section filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
2. New subsection (c) filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2792.30. Rescission Rights.

A person who has made an offer to purchase an interest in an undivided interest subdivision may exercise the right of rescission granted by Section 11000.2 of the Code by giving written notification of the election to rescind to the subdivider at the place of business designated by the subdivider pursuant to Section 2792.31 of these regulations.

If the notice of election is by United States mail, it shall be considered given on the date that it is postmarked. If the notice is sent by telegraph, it shall be considered as given when transmitted by telegraph from the place of origin. If notification is by means of writing sent other than by United States mail or telegraph, it shall be considered as given at the time of delivery at the place of business designated by the subdivider.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11000.2, Business and Professions Code.

HISTORY

1. New section filed 5–4–89; operative 6–3–89 (Register 89, No. 23).

§ 2792.31. Notice of Rescission Rights.

(a) To inform a person of his/her right of rescission under Section 11000.2 of the Code, the subdivider shall attach to the face page of every copy of a subdivision public report given to a prospective purchaser, the notice set forth in subdivision (b) hereof printed in not less than 12–point bold face capital letters and numerals.

(b) The form and content of the notice shall be as follows:

IF YOU MAKE AN OFFER TO PURCHASE AN UNDIVIDED INTEREST(S) IN THE UNDIVIDED INTEREST SUBDIVISION IDENTIFIED BELOW, YOU HAVE A LEGAL RIGHT TO RESCIND (CANCEL) THIS OFFER, AND ANY CONTRACT RESULTING FROM THE ACCEPTANCE OF YOUR OFFER, AND THE RETURN OF ALL MONEY AND OTHER CONSIDERATION THAT YOU HAVE GIVEN TOWARD THE PURCHASE UNTIL MIDNIGHT OF THE THIRD CALENDAR DAY AFTER THE DAY ON WHICH YOU SIGN THE OFFER TO PURCHASE.

YOU MAY EXERCISE THIS RIGHT TO RESCIND WITHOUT GIVING ANY REASON AND WITHOUT INCURRING ANY PENALTY OR OBLIGATION BY NOTIFYING

_____

_____
(Name of Subdivider)

AT _____

_____
(Address)

OF YOUR ELECTION TO RESCIND BY TELEGRAPHIC COMMUNICATION, MAIL OR OTHER WRITTEN NOTICE.

IF THE NOTICE OF RESCISSION IS SENT BY UNITED STATES MAIL, IT SHALL BE CONSIDERED GIVEN ON THE DATE THAT IT IS POSTMARKED. IF THE NOTICE IS BY TELEGRAPHIC COMMUNICATION, IT SHALL BE CONSIDERED GIVEN WHEN TRANSMITTED FROM THE PLACE OF ORIGIN. IF NOTIFICATION IS BY MEANS OF A WRITING TRANSMITTED OTHER THAN BY UNITED STATES MAIL OR TELEGRAPH, IT SHALL BE CONSIDERED GIVEN AT THE TIME OF DELIVERY AT THE ABOVE PLACE OF BUSINESS.

YOU MAY USE THIS NOTICE FOR THE PURPOSE OF RESCINDING YOUR OFFER TO PURCHASE BY COMPLETING THE BLANKS AND BY DATING AND SIGNING BELOW. THE USE OF REGISTERED OR CERTIFIED MAIL WITH RETURN RECEIPT REQUESTED IS RECOMMENDED FOR TRANSMITTAL OF THIS NOTICE BY MAIL.

_____ _____
(Name of Undivided Interest Subdivision) (DRE File Number)

I HEREBY RESCIND MY OFFER OF _____
(Date)

TO PURCHASE AN UNDIVIDED INTEREST

_____
(Identification Number, If Known)

IN THE ABOVE–NAMED UNDIVIDED INTEREST SUBDIVISION.

_____, 19____.
(Date)

_____
(Signature)

_____
(Signature)

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11000.2, Business and Professions Code.

HISTORY

1. New section filed 5–4–89; operative 6–3–89 (Register 89, No. 23).

§ 2792.32. Alternative Arrangements for Master Planned Communities.

(a) A "Master Planned Development" is a development which ordinarily satisfies all of the following criteria:

(1) The development is or will be a planned development subdivision within the meaning of subdivision (k) of Section 1351 of the Civil Code.

(2) The development consists of, will generally consist of, or is proposed to consist of both (a) approximately five hundred (500) or more separate residential interests, and (b) one or more subdivisions, including planned developments, community apartment projects, condominium projects, stock cooperatives, time–share projects, or other residential, recreational, commercial, or mixed residential/non–residential projects.

(3) The Master Planned Development shall be managed by a community association ("Master Association") that is responsible for the maintenance and operation of areas and/or facilities affecting the Master Planned Development and enforcement of use restrictions pertaining to the Master Planned Development.

(4) The Master Planned Development is or will be developed in two or more phases.

Provided, however, the subdivider may demonstrate from specific facts and circumstances that a development that does not satisfy the criteria set forth in this subsection (a) should nonetheless be treated as a Master Planned Development.

(b) Recognizing that control by the subdivider over the governing body serving a residential common interest development and over the architectural control committee serving the development is ordinarily necessary until a reasonable portion of the project has been completed, in order to fulfill the expectations of the subdivider and the purchasers, the governing instruments for a Master Association shall substantially conform to the applicable standards prescribed in subsections (c) through (g), inclusive, below.

(c) SUBDIVIDER'S MEMBERSHIP VOTING RIGHTS: The governing instruments for a Master Association may include provisions for two classes of membership as defined in Section 2792.18(b). For such a Master Association, Class B membership shall be automatically converted to Class A membership and Class B membership shall thereafter cease to exist on the first to occur of the following:

(1) When seventy–five percent of the separate residential interests proposed for the overall Master Planned Development have been conveyed to Class A members;

(2) On the fifth anniversary following the most recent conveyance to a Class A member of the first separate residential interest in any phase of the overall Master Planned Development under the authority of a public report; or

(3) On the twenty–fifth anniversary of the first conveyance of a separate residential interest to a Class A member in the overall Master Planned Development under the authority of a public report.

(d) DELEGATE VOTING: The governing instruments for a Master Association may include provisions for establishing a geographical area in the Master Planned Development for one or more delegates to represent the collective voting power of the members residing in such residential or mixed residential/non–residential projects within the Master Planned Development. Arrangements in the governing instruments for the exercise of the voting power of the Master Association by delegates selected by each delegate district shall conform to the following criteria:

(1) The governing instruments must establish a procedure for the selection of delegates, for defining delegate districts, and for determining the number of votes that may be cast by a delegate.

(2) There shall be at least one delegate and one alternate for each delegate district.

(3) In any meeting of the members of the Master Association, the votes of members residing in a delegate district shall be cast by delegates selected to represent that delegate district.

(4) The duties of the delegates shall be prescribed in the governing instruments.

(e) QUORUM FOR MEMBERSHIP MEETINGS: The quorum for an adjourned meeting of the members of the Master Association, as described in Section 2792.17(e)(2) of these Regulations, may be set by the governing instruments at a percentage less than that prescribed for the regular meeting, but it shall not be less than 15 percent of the total voting power of the Master Association.

(f) GOVERNING BODY MEMBERSHIP:

(1) The governing instruments may include provision for the election of a majority of the governing body of the Master Association by the subdivider under a Class C vote or similar device. For such a Master Association, this arrangement shall irreversibly terminate on the first to occur of the following:

(A) When seventy–five percent of the separate residential interest proposed for the overall Master Planned Development have been conveyed to Class A members;

(B) On the fifth anniversary following the most recent conveyance to a Class A member of the first separate residential interest in any phase of the overall Master Planned Development under the authority of a public report; or

(C) On the twenty–fifth anniversary of the first conveyance of a separate residential interest to a Class A member in the overall Master Planned Development under the authority of a public report.

(2) The governing instruments may include provision for the election of twenty percent of the members of the board of directors of the Master Association by the subdivider until the first to occur of the following:

(A) When ninety percent of the subdivision interests in the overall development have been conveyed to Class A members;

(B) On the fifth anniversary following the most recent conveyance to a Class A member of the first separate residential interest in any phase of the overall Master Planned Development under the authority of a public report.

(C) On the twenty–fifth anniversary of the first conveyance of a separate residential interest to a Class A member in the overall Master Planned Development under the authority of a public report.

(g) ARCHITECTURAL CONTROL: Members appointed to the Architectural Control Committee by the governing body or by the subdivider need not be members of the Master Association. The governing instruments may include provision for the election of a majority of the Architectural Control Committee of the Master Association by the subdivider. This arrangement shall irreversibly terminate on the first to occur of the following:

(1) When ninety percent of the subdivision interests proposed for the overall Master Planned Development have been conveyed to Class A members; or

(2) On the fifth anniversary following the most recent conveyance to a Class A member of the first separate residential interest in any phase of the overall Master Planned Development under the authority of a public report.

(h) ADDITIONAL ASSOCIATIONS: If any residential structure or other major special benefit facility or amenity will be constructed or provided within the Master Planned Development and commonly maintained or operated for the use or benefit of some but not all of the homeowners within the Master Planned Development, ordinarily one or more separate homeowners associations shall be established under arrangements substantially satisfying the requirements of Sections 2792.4, 2792.8(a), and 2792.15 to 2792.26, inclusive, of these Regulations to maintain the residential structure or to maintain and operate the major special benefit facility or amenity and to enforce any obligation or commitment, and any bond or other arrangement securing such obligation or commitment, relating to the residential structure or major special benefit facility or amenity.

(i) Notwithstanding the foregoing, the subdivider may present to the Commissioner specific facts an circumstances relating to a Master Planned Development that demonstrate the need for alternative arrange-

ments, satisfactory to the Commissioner, from those provisions set forth in subsections (c) through (h) above.

(j) The subdivider of a Master Planned Development may enter into an arrangement with the Master Association to sell or to convey under a lease purchase arrangement common area amenities to the Master Association. The provisions of this subsection are not available to anyone other than the subdivider of a Master Planned Development. The sale or lease purchase arrangement shall include:

(1) All common area amenities subject to this arrangement shall be specifically identified and defined as "common area" or "future common areas" in the CC&Rs. The common area amenity must be a part of the proposed Master Planned Development, accessible to all homeowners who will be charged an assessment to pay for the amenity and must be located on a separate lot or parcel. The term common area shall not include any element or amenity within a separate interest or unit.

(2) All common area amenities subject to this arrangement that have not been completed shall be covered by a bond or other arrangement to secure completion of the amenities.

(3) The Master Association shall not be obligated to make any payments nor shall any homeowner be required to pay any assessment for common area amenities subject to this arrangement until those amenities have been completed and a Notice of Completion as defined in Civil Code Section 3093 has been recorded.

(4) The CC&Rs must obligate the Master Association to maintain and control the common area amenities subject to this arrangement after the sale or lease purchase and to act on those amenities, as appropriate, during the term of the sale or lease purchase.

(5) Title to the common area amenities shall be delivered free and clear of any liens or blanket encumbrances to the Master Association upon completion of the sale or lease purchase. All encumbrances affecting the common area amenities shall include assurances that the ownership or use by the Master Association shall not be adversely affected.

(6) The purchase price of the common area amenities shall not exceed the cost of construction of those amenities. The master subdivider shall provide a bond to secure completion of construction. The Department may, in its discretion, determine whether the purchase price of the common area amenities exceeds the cost of construction of those amenities. In order to make that determination, the Department may review construction bids, records or analyses submitted by the subdivider and, if deemed necessary, may request an independent third party evaluation. The costs of any independent third party evaluation shall be paid by the subdivider.

(7) The term of the sale or lease purchase arrangement shall not exceed ten (10) years and shall provide for substantially equal monthly payments by the Master Association sufficient to fully amortize the sale or lease purchase. The terms of the sale or lease purchase agreement shall be fair, just and equitable and may not provide for a prepayment penalty, negative amortization or balloon payments. Payments on the sale or lease purchase arrangement shall begin not later than three years from the date a Notice of Completion as defined in Civil Code Section 3093 has been recorded unless the Department has approved a longer time period.

(8) The master subdivider shall submit to the Department, prior to use or execution all sale or lease purchase agreements, covenants and documents relating to the sale or lease purchase agreement.

(9) The sale or lease purchase arrangement shall specify who is responsible for maintenance, insurance, reserves and operation of the common area amenities. In a lease purchase arrangement, the subdivider shall pay the property taxes attributable to the common area amenities. The subdivider shall post a bond or other form of acceptable security to insure performance if the master subdivider is responsible for any task requiring such security.

(10) The sale or lease purchase arrangement shall provide for the distribution of proceeds and the action to be taken in the event of condemnation or destruction.

(11) The Master Association CC&Rs and budget shall provide for: specific language binding the Association to fund the common area amenities prior to, during and after acquisition of the amenities; the ability of the Association to address issues related to the operation of the common area amenities while they are subject to a sale or lease purchase arrangement; sufficient funds to meet the monthly obligations of the sale or lease purchase arrangement, including a minimum 5% sinking fund to cover defaulting individual homeowner payments until such time as the sinking fund equals the outstanding balance; reserve payments for the common area amenities commencing upon recordation of a notice of completion; and, the right of the Master Association to file liens against the interests of homeowners who have failed to pay their respective portion of the sale or lease purchase costs. Individual homeowner assessments to create the sinking fund shall begin upon the commencement of payments by the Master Association under the sale or lease purchase arrangement. The sinking fund may only be used to cover defaulting individual homeowner payments on the common area amenities covered by the sale or lease purchase arrangement.

(12) The sale or lease purchase arrangement and agreements shall not be modified without the assent of a simple majority of the owners other than a subdivider.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 5–9–90; operative 6–8–90 (Register 90, No. 25).
2. Repealer and new section, and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
3. New subsections (j)–(j)(12) filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2792.33. Continuing Care Subdivisions.

(a) A "Continuing Care Subdivision" is a subdivision described in Section 11004.5 of the Code that includes all of the following:

(1) The subdivision qualifies as housing for older persons pursuant to 42 USC 3607(b)(2)(c) and Section 51.3 of the California Civil Code.

(2) The subdivision offers or provides to its members continuing care services or assisted living services as described in Section 1771 of the Health and Safety Code.

(3) The continuing care provider is a person or entity responsible for providing such continuing care services or assisted living services.

(b) Notwithstanding the provisions of Sections 2792.17, 2792.18, 2792.19 and 2792.21, the governing instruments of a continuing care subdivision may provide for the following:

(1) A quorum for an adjourned meeting of the members of the Association as set forth in Section 2792.17(e)(2) of not less than 15 percent of the total voting power of the Association.

(2) Two classes of membership as defined in 2792.18.

(A) The continuing care provider may be a Class B member. Class B membership entitles the holder to not more than three votes for each subdivision interest owned.

(B) The continuing care provider or its successor may hold at least one Class B membership for as long as the provider or successor provides continuing care services or assisted living services for the subdivision.

(C) The governing instruments shall contain provisions for the resolution of impasses or disputes between Class A and Class B memberships.

(3) The election by Class B membership of 20 percent of the members of the governing body of the Association.

(4) The governing body of the Association may enter into an agreement with a continuing care provider to provide for members of the Association continuing care services or assisted living services as described in Section 1771 of the Health and safety Code. Such agreements shall ordinarily include at least the following provisions:

(A) A term of not more than five years with automatic renewals for a two year period after expiration of the first term unless the Association by the vote or written assent of a majority of the voting power residing in members other than the subdivider or continuing care provider determines not to renew the agreement and gives notice of that determination. Notice of a determination not to renew shall be given not less than six months prior to expiration of the first term or of a subsequent renewal.

(B) Termination for cause at any time by the governing body.

(C) Review by the governing body not less than every two years of the performance of the continuing care provider.

(D) No agreement to provide continuing care services or assisted living services shall be terminated unless the governing body has entered into an agreement with another continuing care provider so that there will be no lapse in services provided to members.

(c) The provisions of this section and Section 2792.21 do not apply to continuing care services or assisted living services agreements between a continuing care provider and individual members.

(d) If the State Department of Social Services determines in writing that a conflict exists under Section 1775 of the Health and Safety Code, the Commissioner may vary some of the requirements of the following regulations in order to remove such conflict: 2792.8, 2792.9, 2792.15, 2792.16, 2792.17, 2792.18, 2792.19, 2792.20, 2792.21, 2792.23, 2792.24, 2792.26, 2792.27 and 2792.28.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code; and Section 1775, Health and Safety Code.

HISTORY

1. New section filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2793. Applications for Consent Under Section 11018.7.

(a) Application for consent of the Real Estate Commissioner under Section 11018.7 of the Business and Professions Code shall be made on a form provided by the department.

(b) The application shall consist of at least the following:

(1) A statement signed by or on behalf of the applicant containing the following:

(A) A narrative explanation of the proposed change and the anticipated effects thereof.

(B) The reasons why the amendment is being proposed.

(C) The means whereby persons eligible to vote on the proposed change will be informed concerning the substance of the change, and the voting procedure to be employed if the consent of the commissioner is obtained.

(D) Identification of the subdivisions which will be affected by the proposed change by reference to the file numbers of the public reports for the subdivisions.

(2) A copy of the instrument to be amended in its present form.

(3) A copy of the instrument incorporating the changes proposed in the application with suitable marking to indicate proposed amendments.

(4) A copy of the resolution or other authority for submission of the application if made on behalf of a corporation or association.

(5) A copy of the letter or notice to be given to all persons eligible to vote on the proposed change.

(6) An application fee of twenty dollars ($20.00) in the form of a check or money order.

(c) If the commissioner finds that the proposed change will not materially change the rights of any owner to ownership, possession or use of interests in the subdivision, the commissioner shall consent to the submission of the proposed change to a vote of the owners or members. If the commissioner finds that the proposed change will materially change such rights, the commissioner shall require, as a condition of the commissioner's consent, that a notice approved by the commissioner describing the substance of the proposed change be given to those persons eligible to vote at least fifteen days prior to the vote.

(d) If the commissioner determines that the change as proposed would create a new condition or circumstance that would be the basis for denial of a public report under Section 11018 or 11018.5, the commissioner shall issue a formal order denying consent to the submission of the proposal to persons eligible to vote thereon.

(e) If an applicant fails to take the steps necessary to obtaining the consent of the commissioner within ninety days after the application is filed, the commissioner may deem the application to be abandoned in which case a new application must be filed if the application is to be thereafter pursued.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code. Reference: Section 11018.7, Business and Professions Code.

HISTORY

1. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
2. Repealer and new section filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49).
3. Amendment of section and repealer and new NOTE filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2794. Use of Final Public Reports.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018, Business and Professions Code.

HISTORY

1. Amendment filed 7–30–51 as an emergency; effective upon filing (Register 25, No. 3).
2. Amendment filed 11–21–61; effective thirtieth day thereafter (Register 61, No. 23).
3. Repealer filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
4. New section filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
5. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2795. Preliminary Public Report.

(a) If a subdivider makes application and pays the appropriate fee, a preliminary subdivision public report may be issued by the Department in advance of satisfaction of all requirements for issuance of a final public report when in the judgment of the Commissioner it is reasonable to expect that all of the requirements for the issuance of a final public report will be satisfied in due course.

(b) A subdivider and persons acting on his behalf may solicit and accept reservations to purchase or lease subdivision interests under authority of a preliminary public report if there is compliance with each of the following:

(1) The person making the reservation (potential buyer) has been given a copy of the preliminary public report and has executed a receipt for a copy before any money or other thing of value has been accepted by or on behalf of the subdivider in connection with the reservation.

(2) A copy of the reservation instrument signed by the potential buyer and by or on behalf of the subdivider, along with any deposit taken from the potential buyer, is placed into a neutral escrow depository acceptable to the Commissioner.

(3) The reservation instrument used is a form previously approved by the Department with at least the following provisions:

(A) The right of either subdivider or potential buyer to unilaterally cancel the reservation at any time.

(B) The payment to the potential buyer of his total deposit on cancellation of the reservation by either party.

(C) The placing of the deposit into an interest bearing account for the benefit of the prospective buyer at the prospective buyer's request and upon the prospective buyer's agreement to pay any charges of the escrow depository for this service.

(c) The initial term of a preliminary public report shall not exceed one year from the date of issuance. The authority to use a preliminary public report shall automatically terminate with respect to those subdivision interests covered by a final public report which is issued before the scheduled termination date of the preliminary report.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.1, Business and Professions Code.

HISTORY

1. Amendment filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50). For prior history see Register 66, No. 25.
2. Repealer and new section filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Amendment of subsection (b)(3) filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2795.1. Receipt for Final or Preliminary Public Report.

(a) A receipt on the form specified herein shall be taken by or on behalf of the subdivider from each person executing a reservation agreement under authority of a preliminary public report and each person who has

made a written offer to purchase or lease a subdivision interest under authority of a final subdivision public report.

(b) The subdivider or his agent shall retain each receipt for a public report for a period of three years from the date of the receipt and shall make the receipts available for inspection by the Commissioner or his designated representative during regular business hours.

(c) The form approved by the Commissioner for the acknowledgment of receipt of a final or preliminary public report as follows:

RECEIPT FOR PUBLIC REPORT

The Law and Regulations of the Real Estate Commissioner require that you as a prospective purchaser or lessee be afforded an opportunity to read the public report for this subdivision before you make any written offer to purchase or lease a subdivision interest or before any money or other consideration toward purchase or lease of a subdivision interest is accepted from you.

In the case of a preliminary or interim subdivision public report, you must be afforded an opportunity to read the report before a written reservation or any deposit in connection therewith is accepted from you.

In the case of a conditional subdivision public report, delivery of legal title or any other interest contracted for will not take place until issuance of a final public report. Provision has been made in the sales agreement and escrow instructions for the return to you of the entire sum of money paid or advanced by you if you are dissatisfied with the final public report because of a material change. (See California Business and Professions Code Section 11012.)

DO NOT SIGN THIS RECEIPT UNTIL YOU HAVE RECEIVED A COPY OF THE REPORT AND HAVE READ IT.

I have read the commissioner's public report on

_____
(File No.) (Tract No. or Name)

I understand the report is not a recommendation or endorsement of the subdivision, but is for information only.

The date of the public report which I received and read is

_____ _____
(Date Issued) (Date Amended)

_____
Name

_____
Address

_____
(Date)

Subdivider Is Required to Retain This Receipt for Three Years.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.1, Business and Professions Code.

HISTORY

1. Amendment filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50). For prior history see Register 66, No. 25.
2. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
3. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
4. Amendment of subsection (b) filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
5. Amendment of subsection (c) filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2795.2. Delivery of Subdivision Public Report to Advertising Media.

HISTORY

1. New section filed 11–21–61; effective thirtieth day thereafter (Register 61, No. 23).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2795.3. Term of Public Report and Extension Thereof.

The term of any Final Subdivision Public Report issued pursuant to Section 11018 of the Business and Professions Code shall be limited to five (5) years. A renewal shall be issued if the subdivider, owner or agent makes application for renewal of any report and has submitted such additional information as the commissioner may require.

HISTORY

1. New section filed 4–5–62; effective thirtieth day thereafter (Register 62, No. 7).
2. Amendment filed 12–30–70; effective thirtieth day thereafter (Register 71, No. 1).

§ 2796. Procedure Re Subdivisions Prior to August 11, 1933.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11000 and 11010, Business and Professions Code.

HISTORY

1. Amendment filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
2. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2797. Townhouse Units.

For purposes of applying Sections 11003 and 11004.5 of the Code, subdivisions consisting of units in close proximity to each other will be deemed to be a "planned development" if all of the following exist:

(a) The units will feature airspace separation between the individual units and will be independent structurally from the other units.

(b) All utility lines, except for the fire service line as described below, serving the individual units will consist of separate lines which run through easements located in accessible areas capable of maintenance by each owner of a unit. Such easements will be established in the CC&R's. A fire service main will run through the easement and will branch off from the main to each unit.

(c) The individual homeowners will be responsible for exterior maintenance of their unit. The exterior stucco will contain architectural enhancements, which will indicate the boundaries between the units.

(d) The homeowners association will maintain, repair and replace the roof. The association budget will include a reserve item for roof replacement.

(e) The association will also have other limited maintenance responsibilities, such as, fire extinguisher cabinets, fire extinguishers, electrical panels, gas meters and telephone panels, gutters and downspouts, address numbers and common exterior lighting. These responsibilities will be described in the CC&Rs or in an exhibit to the CC&Rs specifically allocating responsibility to the association.

(f) Maintenance Manuals and warranty manuals will be prepared to be consistent with this allocation of responsibility and will further elaborate as necessary on the maintenance obligations.

(g) The association is responsible for obtaining property insurance for each residential unit, excluding items typically covered by condominium owners such as personal property, floor and wall surface materials, upgrades installed by the homeowners and liability insurance for injury or damage caused inside the unit. The insurance should cover all components of the unit including the roof, foundation and other exterior elements.

(h) In the event of damage or destruction, the association is responsible for the reconstruction of the units.

(i) The unit owners will receive a separate disclosure to be signed or initialed describing in detail their maintenance, repair, replacement and insurance obligations. That information will also be included in the subdivision's CCR's. In addition, the subdivision public report will include a special note that there is a separate disclosure, which must be signed by all homebuyers and describing the building configuration, association assessment structure, maintenance responsibilities and financing issues. The report will indicate that the lower than usual association assessment will be offset by higher owner maintenance costs.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11003, 11004.5 and 11018.5, Business and Professions Code.

HISTORY

1. New section filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9). For prior history, see Register 96, No. 46.

§ 2798. Phased Subdivision Development.

If a subdivider, for the purpose of developing and marketing subdivided land in increments or phases, requests and obtains a public report that covers less than all of the contiguous subdivision interests or land

which the subdivider intends ultimately to develop as part of an overall project, a new notice of intention, questionnaire and original filing fee must be submitted in connection with each subsequent application for a public report covering subdivision interests to be annexed to the subdivision interests for which a final public report has previously been issued.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11000, 11010 and 11011, Business and Professions Code.

[The next page is 783.]

HISTORY

1. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2799. Use of Public Report in Advertising Restricted.

HISTORY

1. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2799.1. Subdivision Advertising Criteria.

(a) Standards which will be applied by the Real Estate Commissioner in determining whether advertising for sale or lease of subdivision interests is false, untrue or misleading within the meaning of those terms in Sections 10140, 10177(c), 11022 and 17500 of the Business and Professions Code shall include, but shall not be limited to the following:

(1) Advertising shall not imply a use of a subdivision interest that is not set forth in the Notice of Intention and Questionnaire comprising the application for a public report or permit.

(2) A subdivision shall not be advertised under a name, designation or appellation that is not set forth in a Notice of Intention and Questionnaire.

(3) A subdivision shall not be advertised by a name or trade style which implies, contrary to fact, that the subdivider or his agent is a bona fide research organization, public agency, nonprofit organization or similar entity.

(4) No improvement, facility or utility service may be advertised unless it has been completed or installed and is available for use, or unless completion and availability for use are assured through bonding or other arrangements approved by the commissioner. If not completed, the estimated date of completion shall be set forth in the advertising.

(5) There shall be no reference to the prospective availability of private facilities outside of the subdivision for the use and enjoyment of purchasers of subdivision interests if the facilities are to be constructed or installed by the subdivider or an affiliated entity unless financial arrangements for completion or installation have been approved by the commissioner.

(6) There shall be no reference to proposed or uncompleted private facilities over which the subdivider has no control unless the estimated date of completion is set forth and unless evidence has been presented to the commissioner that the completion and operation of the facilities are reasonably assured within the time represented in the advertisement.

(7) Unless the facilities and improvements listed below have been completed, or unless financial and other arrangements for completion have been made, subdivided land offered for residential use shall not be described as "improved," "developed," or by similar terms without disclosure of any facility or improvement listed below that is not included in the offering:

(A) Paved roads within the subdivision.

(B) A potable water system.

(C) A sewage system.

(D) A source of electricity at the building site.

(8) Reference shall not be made to a proposed public facility or project which purports to affect the value and utility of subdivided lands without a disclosure of the existing status of the proposed facility based upon information supplied or verified by the authority responsible for the public facility or project.

(9) A subdivider shall not advertise the availability of financing for on–site construction unless he has a bona fide written expression of an intention to finance such construction by a recognized lender or unless the subdivider has established to the satisfaction of the commissioner that financing of on–site construction will be provided by a source other than a recognized lender.

(10) Pictoral or illustrative depictions of the subdivision and surrounding lands must accurately portray the land as it exists and proposed improvements as they will be constructed.

(11) Pictoral or illustrative depictions other than unmodified photographs shall bear a prominent disclosure identifying the nature of the depiction, e.g., ARTIST'S CONCEPTION and a legend identifying those improvements which are not then in existence.

(12) If a map or diagram is used to show the location of the subdivision in relation to other places, actual road miles from each other place to the subdivision shall be shown or the map or diagram shall be prepared to scale and shall include a scale of miles.

(13) If there is advertising of streets, roads, sewers, storm drains or other utilities which have not been accepted for maintenance by a public entity, that fact must be disclosed in the advertising. Rights–of–way for passenger vehicles to a subdivision or to lots within a subdivision which have not been accepted for maintenance by a public entity shall be adequately described in terms of roadbed and surfacing.

(14) If the existence of a lake, river, canal or other body of water, which is subject to a fluctuating water level other than through natural causes, is advertised as a feature of the subdivision, any significant effect of the fluctuation upon the use of the water facility and upon the subdivision interests shall be described.

(15) No advertisement shall imply that a facility is available for the exclusive use of purchasers of subdivision interests if a public right of access or of use of the facility exists.

(16) There shall be no reference to the availability for use by owners of subdivision interests of private clubs or facilities in which an owner will not acquire a proprietary interest through purchase of a subdivision interest without an accompanying disclosure that the existence of the facilities and their availability for use by subdivision interest owners are at the pleasure of the owner of the facility.

(17) An advertisement of any facility in which a purchaser will acquire a proprietary interest with his purchase of a subdivision must set forth the estimated costs and other obligations of the purchaser with respect to the facility or shall refer the purchaser to a fact sheet or similar source of this information.

(18) No representation may be made that subdivision interests being offered for sale can be further divided unless a full disclosure is included as to the legal requirements for further division of the interests.

(19) Subdivision interests may not be advertised as available at a particular minimum price if the number of subdivision interests available at that price comprise less than 10% of the unsold inventory of the subdivider, unless the number of lots then for sale at the minimum price is set forth in the advertisement.

(20) Advertising of a discounted purchase price shall not be made unless the subdivider has established base prices for application of the discount through a substantial number of sales at base prices.

(21) A prospective increase in the price of a subdivision interest other than an interest offered with an on–site residential, commercial or industrial structure may not be implied nor shall a price increase of such a subdivision interest be announced more than sixty days prior to the date that the increase will be placed into effect.

(22) If the phrase "closing costs only" or similar terminology is used to describe the price of a subdivision interest, the estimated dollar amount of the costs must be set forth in the advertisement.

(23) The total amount of any special bonded indebtedness, or the range of such bonded indebtedness, against the subdivision interests shall be set forth in any advertisement which states or implies that off–site improvements for the subdivision have been completed and paid for in connection with the development of the project. If the selling price of a subdivision interest is advertised, the special bonded indebtedness against that subdivision interest shall be given equal prominence with the selling price unless the bonded indebtedness is included in the advertised selling price.

(24) No representation shall be made as to the availability of a resale program offered by or on behalf of the subdivider unless the resale program has been made a part of the offering as submitted to the commissioner.

(25) An asterisk or other reference symbol may be used to explain, but not to contradict or to change the ordinary meaning of the material in the body of the advertisement.

(26) Unless an offer made in connection with a sales promotion is unequivocally without conditions, the terms "free," "no obligation" or terms of similar import may not be used to describe that which is offered.

(27) Offers of travel, accommodations, meals or entertainment at no cost or reduced cost, the purpose of which is to promote sales, shall not be described as "awards," "prizes" or by words of similar import.

(28) Offers or solicitations of trip reservations to visit subdivided property or any other place where a sales presentation for subdivided property is to be made shall set forth all conditions, limitations or qualifications that will be applied before the recipient will be allowed to make the trip.

(29) The approximate retail value of any gift, prize or premium offered through an advertisement to prospective purchasers shall be set forth in the advertisement.

(30) Complete rules and procedures for any contest or drawing advertised in connection with the marketing of subdivision interests shall be included in the advertisement, or the advertisement shall state the means by which a person can secure full information concerning said rules and procedures prior to his participation in the contest or drawing.

(31) Advertising shall not include testimonials or endorsements which contain matters which the subdivider would be precluded by law or regulation from making in his own behalf.

(32) An offer or inducement to purchase which purports to be limited as to quantity or restricted as to time shall set forth the numerical quantity and/or time applicable to the offer or inducement.

(33) An advertisement or an offering of undivided or fractional interests in a subdivision, which does not include a right of exclusive ownership or occupancy of a particular lot, parcel or unit by the purchaser, shall disclose the total number of undivided or fractional interests to be offered for sale in the subdivision.

(34) If the subdivision offering involves something less than a fee interest with an exclusive and perpetual right to occupy a lot, parcel or unit, e.g., a leasehold or time–sharing–ownership interest, the limitations and restrictions on occupancy rights shall be included in the advertisement or the advertisement shall refer the purchaser to a fact sheet or similar source of this information.

(35) No direct mail advertisement purporting to have resulted through a referral shall be used unless the solicitation includes the name of the person making said referral.

(36) Investment merit or profit potential of a subdivision interest other than an interest which is offered with an on–site residential, commercial or industrial structure shall not be expressed or implied unless the commissioner has determined from evidence submitted by or on behalf of the subdivider that the representation is neither false nor misleading.

(37) Statements appearing in the public report for a subdivision shall not be quoted, paraphrased or cited out of context nor shall any part of the public report be underscored, italicized, bold faced or otherwise highlighted except in strict conformance with highlighting in the public report itself.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 10140, 10177, 11022 and 17500, Business and Professions Code.

HISTORY

1. New section filed 9–18–63; effective thirtieth day thereafter (Register 63, No. 14).
2. Amendment filed 12–30–70; effective thirtieth day thereafter (Register 71, No. 1).
3. Repealer and new section filed 12–7–73; effective thirtieth day thereafter (Register 73, No. 49).
4. New subsection (a)(37) filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2799.2. Advertising Review Fee.

A submission of each advertisement to the Department for approval pursuant to Section 11022 of the Code shall be accompanied by a fee of seventy–five dollars ($75).

NOTE: Authority cited: Sections 11001 and 11022, Business and Professions Code. Reference: Section 11022, Business and Professions Code.

HISTORY

1. New section filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2800. Notification of Material Change.

The owner of a subdivision which is the subject of an outstanding public report shall immediately report in writing to the Real Estate Commissioner relevant details concerning any material change in the subdivision itself or in the program for marketing the subdivision interests. A material change in the subdivision or in the offering shall include, but shall not be limited to the following:

(a) The sale, conveyance, including a transfer of title in trust, or the granting of an option to another to acquire, five or more subdivision interests in a subdivision other than a time–share project or twelve or more time–share estates or time–share uses in a time–share project.

(b) Change in the name or organization of the subdividing entity such as incorporation, dissolution of corporation or change in corporate or fictitious business name.

(c) Change in purchase money handling procedures under Section 11013.2 or 11013.4 of the Code including but not limited to a change in name or location of escrow or trust account depository or the creation of a blanket lien or encumbrance affecting a lot, parcel or unit of subdivided land being offered for sale.

(d) Change in methods of marketing or conveyance of subdivision interests, including but not limited to the following:

(1) Use of real property sales contracts, lease–option agreements or similar marketing instruments.

(2) Special sales inducements involving a financial commitment to purchasers by or on behalf of the subdivider such as buy–back agreements, special interest rates or a short–term basis and prizes, gifts or premiums.

(e) Inability of the subdivider to fulfill agreements and assurances to purchasers of subdivision interests given by the subdivider to the commissioner in the application for a public report.

(f) Creation or discovery of latent hazards affecting the subdivisions such as adverse geologic conditions not apparent at the time of issuance of the current public report for the subdivision.

(g) Addition of common areas or common facilities for the use and enjoyment of owners in the subdivision which were not contemplated at the time of issuance of the current public report for the subdivision.

(h) A relocation of easements affecting unsold subdivision interests.

(i) The creation of a district, or the annexation of the subdivision into a district, having the power to tax or levy assessments against real property interests within the subdivision.

(j) An increase of 20% or more or a decrease of 10% or more in the regular assessment charged by an Association against owners in a common–interest subdivision over the amount of the regular assessment reflected in the current public report for the subdivision.

(k) Delinquencies in the payment of regular assessments by owners within a common–interest subdivision resulting in the receipt by the Association of income which is more than 10% less than scheduled income from said assessments.

(*l*) A proposed change in the use for which the subdivision is offered as, for example, from residential to investment or a proposed change from an offering of the sole and exclusive use of a unit in a common–interest subdivision to a program involving the sharing of ownership or use with others as, for example, a time sharing program.

(m) Changes in the means for furnishing potable water, sewage disposal and other public services to lots, parcels or units within the subdivision.

(n) Any change in the configuration of the subdivision interest being offered for sale from the configuration according to the subdivision map or parcel map upon which the current public report for the subdivision was based.

(o) An amendment to the CC&Rs or other governing instruments for the subdivision or for an association of owners of subdivision interests.

(p) Failure by the subdivider as an owner of interests in a common interest subdivision to pay regular assessments where:

(1) Assessments are payable on a monthly basis and the subdivider has failed to pay three or more months of such assessments.

(2) Assessments are not payable on a monthly basis and the subdivider has failed to pay such assessments within three months after such assessments become due and payable.

(q) A program which does not comply with Section 2792.10 in which the subdivider undertakes to subsidize the cost of operating and maintaining common areas and of providing services in lieu of payment of regular assessments by the subdivider.

(r) The affiliation by a single–site time–share project as defined in Section 11003.5 of the Code with: 1) other time–share projects or accomodations under a contractual or membership program through a mandatory reservation system or 2) a mandatory reservation system.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11010, 11012, 11018 and 11018.5, Business and Professions Code.

HISTORY

1. Repealer and new section filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
2. Amendment of subsection (c) filed 4–24–78; effective thirtieth day thereafter (Register 78, No. 17).
3. Amendment of subsection (j) filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
4. Amendment of subsection (*l*) filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
5. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
6. Adoption of new subsections (p) and (q) filed 7–12–91; operative 8–11– 91 (Register 91, No. 44).
7. Amendment of subsections (c), (p)(1), (p)(2), (q) and NOTE filed 4–1–93; operative 5–3–93 (Register 93, No. 14).
8. New subsection (r) filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).

§ 2801. Notification of Option or Sale by Owner.

HISTORY

1. Repealer filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7). For prior history, see Register 71, No. 50.

§ 2801.5. "Subdivider" Defined.

The term "any person" in Section 11010 and the terms "owner" and "subdivider" in Sections 11012 and 11018.1 of the Code include any person, who at any point in time, owns, or has an option or contract to acquire, the subdivision interests listed in (a) or (b) below for purposes of sale, lease or financing if the subdivision interests were acquired or are to be acquired from the original recipient of a public report for the subdivided land, or from a person who succeeded to the interest of the original recipient in five or more subdivision interests in a subdivision other than a time–share project or in twelve or more time–share estates or uses in a time–share project:

(a) Five or more subdivision interests in a subdivision other than a time–share project.

(b) Twelve or more time–shares estates or time–share uses in a time–share project.

Except as provided in Section 11010.5 of the Code, an "owner" or "subdivider" as herein defined shall not offer for sale or lease, nor cause to be offered for sale or lease, any of the subdivision interests herein above referred to unless a subdivision public report has been issued by the Department expressly authorizing the sale or lease of the interests by or on behalf of said owner or subdivider.

NOTE: Authority cited: Sections 11080 and 11001, Business and Professions Code. Reference: Sections 11000, 11004.5, 11010, 11012, 11018.1, Business and Professions Code.

HISTORY

1. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3). For prior history, see Registers 78, No. 17; 71, No. 50; and 66, No. 25.
2. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
3. Editorial Correction filed 2–6–81 (Register 81, No. 6).
4. Amendment filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).

§ 2802. Reports from Competent Authorities May Be Required.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11010, Business and Professions Code.

HISTORY

1. Repealer of section and new NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2803. Noncontinguous Parcels.

If the notice of intention referred to in Section 11010 of the Code includes lots, parcels or units of subdivided land that are not contiguous to each other, the commissioner will determine which of the lots, parcels or units are sufficiently close together and sufficiently similar to each other in physical and other characteristics to be included within the coverage of a single public report.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11000 and 11010, Business and Professions Code.

HISTORY

1. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2804. Abandoning Application For Public Report.

(a) The commissioner may abandon an application for a final, conditional, amended, or renewed public report, if:

(1) The data required by Section 11010 has not been furnished within three years from the date a notice of intention was filed for the subdivision public report; and

(2) Six months have elapsed since the commissioner has given notice of deficiencies or substantive inadequacies contained in the documents which are required to make the filing substantially complete and the deficiencies and inadequacies have not been corrected by the applicant; and

(3) The term of any one–year extension of time in which to complete the application, as provided in subdivision (d), has elapsed.

(b) Ninety (90) days prior to abandoning an application the commissioner shall mail to the applicant and the applicant's designated representative, notice of the commissioner's intent to abandon the application. The notice shall include a statement that the applicant may, in accordance with subdivision (d), file a petition to keep the application open.

(c) Sixty (60) days or more following the mailing of the notice required by subdivision (b), the commissioner may issue a final notice of intention to abandon the application. The application shall be deemed abandoned thirty (30) days after the final notice is mailed to the applicant and the applicant's designated representative, unless, prior to the expiration of the thirty day period, a one–year extension has been granted pursuant to subdivision (d).

(d) The commissioner, on his own motion, or after receipt of a petition from the applicant or the applicant's designated representative, may, under the following terms and conditions, grant a one–year extension in order to allow the applicant to complete the application:

(1) The petition is received prior to the expiration of the thirty (30) day notice period referred to in subdivision (c).

(2) The petition sets forth reasons of hardship or justifiable extenuating circumstances explaining why the file has been inactive. Hardship and justifiable extenuating circumstances shall include mistake, inadvertence, surprise, excusable neglect, or circumstances beyond the control of the applicant or the applicant's designated representative.

Written notice of the decision to grant or deny the petition will be mailed or delivered to the applicant and the applicant's designated representative, within thirty (30) calendar days after receipt of the petition.

(e) The commissioner may grant one or more one–year extensions, provided that the application has not been abandoned as provided in subdivision (c).

(f) The term "applicant" as used in this section shall have the same meaning as the term "subdivider" as used in Section 11018.13 of the Code.

NOTE: Authority cited: Sections 11001 and 11018.13, Business and Professions Code. Reference: Sections 11010 and 11018.13, Business and Professions Code.

HISTORY

1. New section filed 12–7–94; operative 1–6–95 (Register 94, No. 49). For prior history, see Register 83, No. 30.

Article 12.1. Out–of–State Subdivision Offerings

HISTORY

1. Repealer of article 12.1 (sections 2805–2809) filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

Article 12.2. Time–Share Project

§ 2805. "Developer" Defined.

The terms "developer" in Section 11212 and "any person" in Section 11212 and in Section 11226 of the Code include any person, who at any point in time, owns, or has an option or contract to acquire eleven or more time–share interests for purposes of sale in the ordinary course of business if the time–share interests were acquired or are to be acquired from the original recipient of a public report for the time–share plan, or from a person who succeeded to the interest of the original recipient in eleven or more time–share interests in a time–share plan.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Sections 11211.5, 11212 and 11226, Business and Professions Code.

HISTORY

1. New section filed 2–26–85; effective thirtieth day thereafter (Register 85, No. 9). For history of former Section 2805, see Register 83, No. 30.
2. Amendment of subsection (a) filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
3. Amendment moving section 2805 from article 12.1 to article 12.2. and repealer and new section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).
4. Amendment of section and NOTE filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35).

§ 2805.5. Inducement to Out–of–State Solicitation.

The terms "sells", "offers to sell" and "attempts to solicit prospective purchasers" in Section 11226 of the Code include any written or oral communication which is disseminated or otherwise used within this state for the purpose of inducing a resident to travel outside this state for a required presentation with the primary intention of causing the person to purchase time–share interests located outside of this state.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11226, Business and Professions Code.

HISTORY

1. New section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2805.9. Reservation Rights.

(a) The term "the right to use accommodations at a specific time–share property" used in Section 11212(z)(2)(A) means a priority right of not less than sixty days to reserve accommodations at that specific time–share property without competing with owners of time–share interests at other time–share properties that are part of the multi–site time–share plan.

(b) The term "use rights in accommodations at one or more other component sites" as used in Section 11212(z)(2)(A) means the right, on a non–priority basis, to reserve accommodations in component sites of the multi–site time–share plan.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11212, Business and Professions Code.

HISTORY

1. New section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2805.11. *Impound of Funds to Assure Completion.*

"All funds from the sale of time–share interests as the commissioner shall determine are sufficient to assure construction of the improvement or improvements" as used in Section 11230(b) of the Code, means 100% of all funds received from purchasers up to a maximum of the amount required to complete the improvement or improvements, consistent with Section 11243 of the Code.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Sections 11230 and 11243, Business and Professions Code.

HISTORY

1. New section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2806. Notification of Material Change.

The developer of a time–share plan which is the subject of an outstanding public report shall report to the Department pursuant to Section 11226(f)(1), relevant details concerning any material change in the time–share plan. A material change in the time–share plan includes, but shall not be limited to, the following:

(a) Deletion of an accommodation from the time–share plan or addition of an accommodation not authorized under an existing time–share public report for the time–share plan.

(b) Change in the name or form of organization of the developer such as incorporation, dissolution of a corporation or a change in the corporate or fictitious business name.

(c) Change in the methods of conveyancing of time–share interests such as the use of real property sales contracts.

(d) Change in purchase money handling procedures previously submitted to the Department including but not limited to a change in the escrow depository or the creation of an encumbrance affecting more than one timeshare interest in the time–share plan.

(e) Resignation of the trustee or other change in any of the terms of the trust agreement for the time–share plan.

(f) The existence of either of the following conditions with respect to the corpus of the trust.

(1) Insufficient funds in the trust to satisfy the trust fund provision for payment of debt service, property taxes, assessments and/or insurance premiums for the trust property.

(2) Insufficient non–delinquent installment sales contracts and/or promissory notes to satisfy the provision of the trust agreement for payment of the aggregate principal balance owing under a blanket encumbrance against the trust properties.

(g) Any legal or physical condition rendering an accommodation of the time–share plan unusable by time–share owners for one year or more.

(h) Litigation undertaken by a governmental entity or time–share owners' association seeking to prohibit or restrict the dedication of an accommodation to the time–share plan.

(i) An annual budget for a time–share project which will necessitate a regular annual assessment that is more than 20 percent greater than the regular annual assessment in the certified budget for the immediately preceding year.

(j) An amendment to any provision of the recorded time–share plan or declaration.

(k) A change in any aspect of the offering for the time–share plan which will cause information in the current public report for the project to be incorrect or misleading.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11226, Business and Professions Code.

HISTORY

1. New section filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2). For prior history, see Register 83, No. 30.
2. Amendment of subsection (a)(1) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
3. Amendment of subsection (a)(1) filed 11–16–87; operative 12– 16–87 (Register 87, No. 47).
4. Amendment of subsections (b)(3) and NOTE, and adoption of subsection (b)(4) filed 4–7–92; operative 5–7–92 (Register 92, No. 14).
5. New subsection (a)(3) and amendment of NOTE filed 4–1–93; operative 5–1–93 (Register 93, No. 14).
6. Amendment of section and NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
7. Amendment moving section 2806 from article 21.1 to article 12.2. and repealer and new section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2807. Purchase Money Impounds.

(a) The amount of the money paid or advanced by a prospective buyer toward the purchase of a time–share interest (Purchase Money) that must be deposited and retained in an escrow depository or trust account pur-

suant to Section 11243 of the Code shall ordinarily be the entire amount of the Purchase Money less disbursements made to third parties for services enumerated in subdivision (b) of Regulation 2791.

(b) For purposes of compliance with Section 11243 of the Code:

(1) A proper release has not been obtained from a deed of trust encumbering time-share interests or accommodations in a time-share plan unless an instrument has been duly recorded unconditionally reconveying and releasing the interests being sold or leased from the lien or charge of such deed of trust.

(2) As an alternative to obtaining a proper release from the lien or charge of such deed of trust, it shall be deemed acceptable by the commissioner pursuant to Section 11243 of the Code if:

(A) the holder of the deed of trust has duly executed an agreement or demand ("release agreement") wherein the holder has agreed, notwithstanding any provision to the contrary in the deed of trust, to promptly perform any act reasonably necessary to record an instrument unconditionally reconveying and releasing the time-share interests or accommodations in a time-share plan being sold from the lien or charge of the deed of trust upon payment to the holder of an amount or amounts specified in the release agreement as the release price for the affected time-share interests or accommodations in a time-share plan, and the holder has further agreed that specific performance of the terms and provisions of the release agreement shall be compelled in favor of the purchaser of the time-share interests or accommodations in a time-share plan;

(B) the release agreement has been deposited with the escrow holder for the transaction(s);

(C) the developer has notified each purchaser that the release agreement is available upon request from the escrow holder; and

(D) each purchaser has been provided a policy of title insurance insuring the purchaser or lessee against loss by reason of the deed of trust.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11243, Business and Professions Code.

HISTORY

1. Amendment moving section 2807 from article 12.1 to article 12.2. and new section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18). For prior history, see Register 96, No. 48.

§ 2807.1. Alternative to Purchase Money Impound.

The penal sum of the financial assurances permitted pursuant to Section 11243(c) furnished by or on behalf of a developer shall be in an amount equal to or in excess of the lesser of (1) the funds that would otherwise be placed in escrow, or (2) the cost to complete the incomplete property in which the time-share interest is located. However, in no event shall the amount be less than the amount of funds that would otherwise be placed in escrow pursuant to Section 11243(a)(1).

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11243, Business and Professions Code.

HISTORY

1. New section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2807.2. Acceptable Escrow Depositories.

(a) The following entities which are qualified to do business in the State of California are escrow depositories acceptable to the Commissioner: escrow agents licensed by the Corporations Commissioner, banks, trust companies, savings and loan associations, title insurers and underwritten title companies.

(b) In exceptional circumstances the Commissioner may approve an escrow depository other than an entity enumerated in subdivision (a).

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11243, Business and Professions Code.

HISTORY

1. New section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2807.3. Acceptable Trustees.

A trust company as defined in Section 107 of the Financial Code which is qualified to do business in California is a trustee acceptable to the Commissioner to hold title to a time-share plan pursuant to Section 11243 of the Code. In exceptional circumstances the Commissioner may approve a trustee other than a trust company as defined in Section 107 of the Financial Code.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11243, Business and Professions Code.

HISTORY

1. New section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2807.4. Qualified Budget Certification.

The Budget Review Section of the Department of Real Estate is considered qualified pursuant to Section 11240(f)(3) to determine whether budgets of time-share plans meet the requirements of the Vacation Ownership and Time-share Act of 2004. In the event budget review is to be conducted by the Budget Review Section pursuant to Section 11240(g), budget review may take place concurrently with processing the application for a final public report.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11240, Business and Professions Code.

HISTORY

1. New section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2808. Approved Form of Bond for Completion of Common Facilities.

A bond posted pursuant to Section 11230 to secure the faithful performance of a commitment by the developer to complete common facilities and common-area improvements shall be in substantially the following form:

Bond for Completion of Common Facilities

Bond No._____

Premium: $ _____

KNOW ALL MEN BY THESE PRESENTS, that we _____ (Name of developer), as PRINCIPAL, and _____ (Name of surety), a corporation organized under the law of the State of _____, and authorized to transact the business of surety in the State of California, as SURETY, are firmly held and bound unto _____ (Name of homeowner association) (hereinafter referred to as OBLIGEE) in the penal sum of _____Dollars ($_____) for which sum, well and truly to be paid, we bind ourselves, our heirs, administrators, successors and assigns, jointly and severally, firmly by these presents. This bond is given pursuant to Section 11230 of the California Business and Professions Code to assure lien-free completion of the improvements described in PRINCIPAL's "Planned Construction Statement," a copy of which is attached hereto and incorporated herein by reference, for the time-share development known as _____ (Name of time-share), situated in the County of _____, State of _____.

SURETY, for value received, hereby agrees that the matters set forth in California Civil Code Section 3225, or similar acts or omissions which might release the SURETY pursuant to law, shall not in any way release SURETY from the obligation of this bond or reduce SURETY's obligation thereunder. SURETY, for value received, does hereby waive the right granted to SURETY under California Civil Code Section 2845 to require that OBLIGEE proceed independently against PRINCIPAL to enforce this obligation, but reserves to itself any right under said Section 2845 to require that OBLIGEE proceed jointly against PRINCIPAL and SURETY in any such action.

The condition of this obligation is such that if PRINCIPAL shall complete or cause to be completed said improvements free of liens and claims on or before the latest completion date specified in said "Planned Construction Statement," or an extension thereof given in writing by OBLIGEE to PRINCIPAL and assented to in writing by SURETY, then this obligation shall be null and void; otherwise, it shall remain in full force and effect.

This obligation may be reduced from time to time proportionate to the percentage of the covered improvements which have been completed, upon presentation to the SURETY and OBLIGEE of a statement of an architect or engineer familiar with the project certifying the percentage completion of the improvements.

A suit or action on this bond must be filed within two years after the latest completion date set forth in the "Planned Construction Statement" or any extension thereof given in writing by OBLIGEE to PRINCIPAL and assented to in writing by SURETY.

The SURETY, its successors and assigns, are jointly and severally liable on the obligations of the bond, chapter 2 (commencing with section 995.010), Title 14, part 2, Code of Civil Procedure and Article 2, Chapter 2, Part 2, Division 4, Business and Professions Code.

The PRINCIPAL and SURETY may be served with notices, papers and other documents under chapter 2 (commencing with section 995.010), Title 14, part 2, Code of Civil Procedure at the addresses given below.

The terms, conditions and coverage of this bond have been approved by the Real Estate Commissioner of the State of California.

IN WITNESS WHEREOF, PRINCIPAL and SURETY have caused these presents to be duly signed and sealed this _____ day of _____, 20____

_____	_____
(Principal)	(Surety)
By: _____	By: _____
(Signature)	(Signature)
Address: (for Principal)	Address: (for Surety)
_____	_____
_____	_____
_____	_____

This bond is executed under an unrevoked power of attorney.

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____	_____
Date	Signature of Attorney-in-Fact for Surety
	_____
	Printed or typed name of Attorney-in-Fact for Surety

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11230, Business and Professions Code.

HISTORY

1. Amendment moving section 2808 from article 12.1 to article 12.2. and new section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18). For prior history, see Register 83, No. 30.

§ 2809. Application.

(a) An application for a public report to sell or to offer to sell interests in a time-share plan pursuant to Chapter 2 of Part 2 of the Real Estate Law shall be filed with Department at its principal office in Sacramento along with the applicable fee.

(b) The application shall be signed by or on behalf of the person to whom the permit is to be issued or by an agent with appropriate written authorization on behalf of the person to whom the permit is to be issued. If executed within California, the information in the application and in the document submitted therewith shall be certified to be true under penalty of perjury or verified before a notary public or other person qualified to administer oaths. If executed outside of California, the information in the application and accompanying documents shall be verified before a person qualified to administer oaths within the jurisdiction where executed or certified under penalty of perjury in accordance with the provisions of subdivision (b) of Section 2015.5 of the Code of Civil Procedure.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11226, Business and Professions Code.

HISTORY

1. Amendment moving section 2809 from article 12.1 to article 12.2. and new section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18). For prior history, see Register 83, No. 30.

§ 2809.1. Properly Completed Application — Single-Site Time-Share Plan.

An application for a final public report for a single-site time-share plan is "properly completed" within the meaning of Section 11231 of the Code if it contains the documents and information enumerated below:

(a) For every single-site time-share plan:

(1) The developer's legal name, any assumed names used by the developer, principal office street address, mailing address, primary contact person, and telephone number.

(2) The name of the developer's authorized or registered agent in the state upon whom claims can be served or service of process be had, the agent's street address in California, and telephone number.

(3) The name, street address, mailing address, primary contact person, and telephone number of any time-share plan being registered.

(4) The name, street address, mailing address, and telephone number of any managing entity of the time-share plan.

(5) Consent to service of process upon the Department of Real Estate if applicant is a nonresident of California.

(6) A description of the inventory control system that will ensure compliance with Section 11250 of the Code.

(7) Evidence that the accommodation is presently suitable for human occupancy or that financial arrangements have been made to complete construction or renovation of the accommodation to make it suitable for human occupancy on or before the first date for occupancy by a time-share interest owner.

(8) Evidence that the accommodations are owned or leased by the developer of the time-share plan or is the subject of an enforceable option or contract under which the developer will build, purchase, or lease the accommodations.

(9) If an accommodation in a time-share plan is located within a local governmental jurisdiction or subdivision of real property in which the dedication of accommodations to time-sharing is expressly prohibited by ordinance or recorded restriction, either absolutely or without a permit or other entitlement from the governing body, the applicant for a public report shall present evidence of a permit or other entitlement by the appropriate authority for the local government or the subdivision.

(10) A description of the existing or proposed accommodations, including the type and number of time-share interests in the accommodations.

(11) The number of accommodations and time-share interests expressed in periods of seven-day use availability or other time increments applicable to the time-share plan, and available for use by purchasers and a representation about the percentage of useable time authorized for sale.

(12) A description of any existing or proposed amenities that will be part of the time-share plan.

(13) A description of the financial arrangements that have been made, pursuant to Section 11230, for the completion of any incomplete, promised amenities.

(14) A description of the duration, phases and operation of the time-share plan.

(15) Copy of the budget meeting the requirements of Section 11240, along with the budget certification or request that the budget be certified by the Budget Review Section of the Department of Real Estate, and a description of the method for calculating and apportioning the assessments among purchasers.

(16) A description of any initial or special fee due from the purchaser at closing together with a description of the purpose and method of calculating the fee.

(17) A description of any financing available through the developer.

(18) A description of any liens, defects, or encumbrances on or affecting the title to the time–share interests.

(19) A description of any bankruptcies, pending civil or criminal suits, adjudications, or disciplinary actions of which the developer has knowledge, that would have a material effect on the developer's ability to perform its obligations.

(20) A description of any fees or charges to be paid by time–share purchasers for the use of any amenities related to the time–share plan.

(21) A description and amount of insurance coverage provided for the protection of the purchaser.

(22) If applicable, a description of any right of first refusal or other restraint on the transfer of all or any portion of a time–share interest.

(23) A copy of instructions to escrow depository for compliance with Section 11241 including the following:

(A) Name and address of escrow depository.

(B) A description of the nature of the transaction.

(C) Conditions that must be satisfied before escrow can be closed.

(D) Provision for the return to a prospective purchaser of funds deposited toward the purchase of a time–share interest if the escrow for the transaction has not closed on or before a given date.

(24) Evidence of financial arrangements to assure fulfillment of developers obligation to pay assessments for unsold timeshare interests pursuant to Section 11241.

(25) Copy of the contract utilized between the exchange company and a purchaser of a time–share interest and all promotional and informational material delivered to purchasers pertaining to any offered exchange program.

(26) Filing fee including fee for preliminary public report if applicable.

(27) Certificate of qualification from Secretary of State if applicant is a foreign corporation.

(28) Preliminary title report for all accommodations comprising the time–share plan, dated not more than 90 days prior to the date of submission of the application or, if the preliminary title report is dated more than 90 days earlier, with an accompanying letter from the title officer, dated not more than 90 days prior to submission of the application, indicating that state of title has not changed from that set forth in the submitted preliminary title report.

(29) If the offering is a security subject to the jurisdiction of the Department of Corporations, a Department of Corporations permit or interpretive opinion or copy of application for permit or request for interpretive opinion submitted to Department of Corporations.

(30) State or local assessment and improvement bond information if applicable to accommodations in the project.

(31) Copies of all contracts, deeds, fact sheets and other instruments to be used in marketing, financing and conveyancing of time–share interests.

(32) Copy of the covenants to be recorded for the time–share plan pursuant to Section 11251 of the Code.

(33) Copy of trust agreement for the time–share plan if applicable.

(34) Copy of proposed or existing agreements for management of the time–share plan.

(35) Format of fidelity insurance or bond to be obtained for the managing agent of the time–share plan and other employees who will have custody or control of funds of the Association.

(36) Copy of letter or other evidence giving notice of the proposed dedication of the timeshare project to local governments in which accommodations of the time–share plan will be located. For time–share projects located outside this state, evidence of approval or compliance of the time–share project in the state in which the time–share project is located is sufficient to satisfy this requirement.

(37) Completed documents for reservations and reservation deposits if a preliminary public report is requested.

(38) Evidence of financial arrangements for any repurchase guarantee included in the offering.

(39) Description of the furnishings and other personal property to be included in the time–share offering.

(40) In a time–share plan which comprises less than all of the accommodations in a hotel, motel or similar commercial lodging establishment and in which the accommodations not part of the time–share plan are concurrently used for transient accommodations, a copy of the proposed contract for the following:

(A) Arrangements for temporary use for transient occupancy of accommodations comprising the time–share plan and temporary use by the time–share plan of accommodations regularly used for transient occupancy.

(B) Apportionment of the costs of operation of the hotel/motel that are for the joint benefit of accommodations in the time–share plan and accommodations for transient occupancy.

(41) Agreement of developer to subsidize maintenance and operation of the single–site time–share plan where applicable.

(42) Description of each incidental benefit pursuant to Section 11237(b).

(43) If applicable, information as required by Section 11233.

(44) If applicable, a certification meeting requirements of Section 11246.

(45) Audited financial statements of the Association, if applicable.

(46) For every single–site time–share plan involving newly–built or as yet unbuilt accommodations, or accommodations which will be renovated or reconstructed prior to occupancy, evidence of availability of domestic utilities and services to the project.

(47) If the time–share plan is located outside this state, a public report or other disclosure document meeting the requirements of Section 11226(c)(5).

(48) A draft public report.

(b) For the sole purpose of determining the effect on the time–share plan, for every single–site time–share plan with accommodations in a condominium development or other common–interest subdivision:

(1) Proposed or existing governing instruments for the common–interest subdivision.

(2) Copies of all contracts or proposed contracts obligating the owners' association of the common–interest subdivision if the subdivision is one for which a public report has not been issued.

(3) If included in the subdivision offering, a copy of agreement of developer to subsidize maintenance and operations of the common interest subdivision if a public report has not been issued for the subdivision.

(4) Financial arrangements to assure performance of the subsidization agreement referred to in (3) above if applicable.

(5) Latest balance sheet and annual operating statement for the owners' association for the common interest subdivision.

(6) Pro–forma budget reflecting estimated ownership, maintenance and operational expenses and reserves for the subdivision.

(7) Financial arrangements to assure fulfillment of developer's obligation to pay assessments for unsold time–share interests if public report has not been issued for the subdivision.

(8) Copy of letters by which the developer has given notice of the proposed dedication of an accommodation to a time–share project to the owners' association of each common–interest subdivision in which an accommodation of the time–share project is located.

(9) Evidence of financial arrangements for completion of common areas and facilities in the subdivision.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Sections 11226, 11231 and 11234, Business and Professions Code.

HISTORY

1. New section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2809.2. Properly Completed Application — Specific Interest Multi–Site Time–Share Plan.

An application for a final public report for a specific time–share interest multi–site time–share plan is "properly completed" within the mean-

ing of Section 11231 of the Code if it contains the documents and information enumerated below:

(a) With regard to the component site(s) in which the purchaser will receive a specific time–share interest along with a reservation priority right at that specific timeshare property, all of the applicable information related to that component site as required under Section 2809.1.

(b) With regard to the component site(s) in which the purchaser does not receive a specific time–share interest, the information required by Section 11234(b) and evidence:

(1) that the accommodation is presently suitable for human occupancy or that financial arrangements have been made to complete construction or renovation of the accommodation to make it suitable for human occupancy on or before the first date for occupancy by a time–share owner, and

(2) that there is an enforceable use right assuring occupancy of the accommodation by a time–share owner.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Sections 11226, 11231 and 11234, Business and Professions Code.

HISTORY

1. New section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2809.3. Properly Completed Application — Nonspecific Time–Share Interest Multi–Site Time–Share Plan.

An application for a final public report for nonspecific time–share interest multi–site time–share plan is "properly completed" within the meaning of Section 11231 of the Code if it contains the documents and information enumerated below:

(a) For every nonspecific time–share interest multi–site time–share plan:

(1) The developer's legal name, any assumed names used by the developer, principal office street address, mailing address, primary contact person, and telephone number.

(2) The name of the developer's authorized or registered agent in the state upon whom claims can be served or service of process be had, the agent's street address in California, and telephone number.

(3) The name, street address, mailing address, and telephone number of any managing entity of the multi–site time–share plan.

(4) Consent to service of process upon the Department of Real Estate if applicant is a nonresident of California.

(5) A description of the inventory control system that will ensure compliance with Section 11250 of the Code.

(6) Evidence that the accommodation is presently suitable for human occupancy or that financial arrangements have been made to complete construction or renovation of the accommodation to make it suitable for human occupancy on or before the first date for occupancy by a time–share interest owner.

(7) Evidence that the accommodations are owned or leased by the developer of the time–share plan or is the subject of an enforceable option or contract under which the developer will build, purchase, or lease the accommodations.

(8) If an accommodation in a time–share plan is located within a local governmental jurisdiction or subdivision of real property in which the dedication of accommodations to time–sharing is expressly prohibited by ordinance or recorded restriction, either absolutely or without a permit or other entitlement from the governing body, the applicant for a public report shall present evidence of a permit or other entitlement by the appropriate authority for the local government or the subdivision.

(9) A description of the type of interest and usage rights the purchaser will receive.

(10) A description of the duration and operation of the time–share plan.

(11) A description of the type of insurance coverage provided for each component site.

(12) An explanation of who holds title to the accommodations of each component site.

(13) A description of each component site, including the name and address of each component site.

(14) The number of accommodations and time–share interests, expressed in periods of seven–day use availability or other time increments applicable to the multi–site time–share plan for each component site committed to the multi–site time–share plan and available for use by purchasers and a representation about the percentage of useable time authorized for sale, and if that percentage is 100%, then a statement describing how adequate periods of time for maintenance and repair will be provided.

(15) A description of each type of accommodation in terms of the number of bedrooms, bathrooms, and sleeping capacity, and a statement of whether or not the accommodation contains a full kitchen. For purposes of this description, a "full kitchen" means a kitchen having a minimum of a dishwasher, range, sink, oven, and refrigerator.

(16) A description of amenities available for use by the purchaser at each component site.

(17) A description of any incomplete amenities at any of the component sites along with a statement as to any assurance for completion pursuant to Section 11230 and the estimated date the amenities will be available.

(18) The historical occupancy of each component site for the prior 12–month period, if the component site was part of the multi–site time–share plan during such 12–month time period, as well as any periodic adjustment or amendment to the reservation system that may be needed in order to respond to actual purchaser use patterns and changes in purchaser use demand for the accommodations existing at that time within the multi–site time–share plan.

(19) A description of any right to make any additions, substitutions, or deletions of accommodations, amenities, or component sites, and a description of the basis upon which accommodations, amenities, or component sites may be added to, substituted in, or deleted from the multi–site time–share plan.

(20) A description of the reservation system that shall include all of the following:

(A) The entity responsible for operating the reservation system, its relationship to the developer, and the duration of any agreement for operation of the reservation system.

(B) A summary of the rules and regulations governing access to and use of the reservation system.

(C) The existence of and an explanation regarding any priority reservation features that affect a purchaser's ability to make reservations for the use of a given accommodation on a first–come, first–served basis.

(21) A description of any liens, defects, or encumbrances that materially affect the purchaser's use rights.

(22) A description of the relationship between a multi–site time–share plan managing entity and the managing entity of the component sites of a multi–site time–share plan, if different from the multi–site time–share plan managing entity.

(23) Copy of the budget meeting the requirements of Section 11240, along with the budget certification or request that the budget be certified by the Budget Review Section of the Department of Real Estate and a description of the method for calculating and apportioning the assessments among purchasers.

(24) Any current fees or charges to be paid by time–share purchasers for the use of any amenities related to the time–share plan and a statement that the fees or charges are subject to change.

(25) Any initial or special fee due from the purchaser at closing with a description of the purpose and the method of calculating the fee.

(26) A description of any financing offered by or available through the developer.

(27) A description of any bankruptcies, pending civil or criminal suits, adjudications, or disciplinary actions of which the developer has knowledge, which would have a material effect on the developer's ability to perform its obligations.

(28) A statement disclosing any right of first refusal or other restraint on the transfer of all or any portion of a time–share interest.

(29) A copy of instructions to escrow depository for compliance with Section 11241 including the following:

(A) Name and address of escrow depository.

(B) A description of the nature of the transaction.

(C) Conditions that must be satisfied before escrow can be closed.

(D) Provision for the return to a prospective purchaser of funds deposited toward the purchase of a time–share interest if the escrow for the transaction has not closed on or before a given date.

(30) Evidence of financial arrangements to assure fulfillment of developer obligation to pay assessments for unsold time–share interests pursuant to Section 11241.

(31) Copy of the contract utilized between the exchange company and a purchaser of a time–share interest and all promotional and informational material delivered to purchasers pertaining to any offered exchange program.

(32) Filing fee including fee for preliminary public report if applicable.

(33) Certificate of qualification from Secretary of State if applicant is a foreign corporation.

(34) Preliminary title report for all accommodations comprising the time–share plan, dated not more than 90 days prior to the date of submission of the application or, if the preliminary title report is dated more than 90 days earlier, with an accompanying letter from the title officer, dated not more than 90 days prior to submission of the application, indicating that state of title has not changed from that set forth in the submitted preliminary title report.

(35) If the offering is a security subject to the jurisdiction of the Department of Corporations, a Department of Corporations permit or interpretive opinion or copy of application for permit or request for interpretive opinion submitted to Department of Corporations.

(36) State or local assessment and improvement bond information if applicable to accommodations in the project.

(37) Copies of all contracts, deeds, fact sheets and other instruments to be used in marketing, financing and conveyancing of time–share interests.

(38) Copy of the covenants for component sites of the multi–site time–share plan in accordance with Section 11251 of the Code.

(39) Copy of trust agreement for the multi–site time–share plan if applicable.

(40) Copy of proposed or existing agreements for management of the multi–site time–share plan.

(41) Format of fidelity insurance or bond to be obtained for the managing agent of the multi–site time–share plan and other employees who will have custody or control of funds of the multi–site time–share plan association.

(42) Copy of letter or other evidence giving notice of the proposed dedication of the timeshare project to local governments in which accommodations of the multi–site time–share plan will be located. For time–share projects located outside this state, evidence of approval or compliance of the time–share project in the state in which the time–share project is located is sufficient to satisfy this requirement.

(43) Completed documents for reservations and reservation deposits if a preliminary public report is requested.

(44) Evidence of financial arrangements for any repurchase guarantee included in the offering.

(45) Description of the furnishings and other personal property to be included in the time–share offering.

(46) In a time–share plan which comprises less than all of the accommodations in a hotel, motel or similar commercial lodging establishment and in which the accommodations not part of the time–share plan are concurrently used for transient accommodations, a copy of the proposed contract for the following:

(A) Arrangements for temporary use for transient occupancy of accommodations comprising the time–share plan and temporary use by the time–share plan of accommodations regularly used for transient occupancy.

(B) Apportionment of the costs of operation of the hotel/motel that are for the joint benefit of accommodations in the time–share plan and accommodations for transient occupancy.

(47) Agreement of developer to subsidize maintenance and operation of the multi–site time–share plan where applicable.

(48) Description of each incidental benefit pursuant to Section 11237(b).

(49) If applicable, information as required by Section 11233.

(50) If applicable, a certification meeting requirements of Section 11246.

(51) Audited financial statements of the multi–site time–share plan association, if applicable.

(52) For every component involving newly–built or as yet unbuilt accommodations, or accommodations which will be renovated or reconstructed prior to occupancy, evidence of availability of domestic utilities and services to the component site.

(53) If the time–share plan is located outside this state, a public report or other disclosure document meeting the requirements of Section 11226(c)(5).

(54) A draft public report.

(b) For the sole purpose of determining the effect on the time–share plan, for every multi–site time–share plan with accommodations in a condominium development or other common–interest subdivision:

(1) Proposed or existing governing instruments for the common–interest subdivision.

(2) Copies of all contracts or proposed contracts obligating the owners' association of the common–interest subdivision if the subdivision is one for which a public report has not been issued.

(3) If included in the subdivision offering, a copy of agreement of developer to subsidize maintenance and operations of the common interest subdivision if a public report has not been issued for the subdivision.

(4) Financial arrangements to assure performance of the subsidization agreement referred to in (3) above if applicable.

(5) Latest balance sheet and annual operating statement for the owners' association for the common interest subdivision.

(6) Pro–forma budget reflecting estimated ownership, maintenance and operational expenses and reserves for the subdivision.

(7) Financial arrangements to assure fulfillment of developer's obligation to pay assessments for unsold time–share interests if public report has not been issued for the subdivision.

(8) Copy of letters by which the developer has given notice of the proposed dedication of an accommodation to a time–share project to the owners' association of each common–interest subdivision in which an accommodation of the time–share project is located.

(9) Evidence of financial arrangements for completion of any promised and not yet completed amenities in the subdivision.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Sections 11226, 11231 and 11234, Business and Professions Code.

HISTORY

1. New section filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).
2. Amendment of subsections (a), (a)(3), (a)(14), (a)(18), (a)(22), (a)(38)–(42), (a)(47) and (a)(51), new subsection (a)(54) and amendment of subsection (b) filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35).

§ 2809.5. Abandoning Application for Public Report.

(a) The commissioner may abandon an application for a final, conditional, amended, or renewed public report, if:

(1) The data required by Sections 11226 and 11234 of the Code has not been furnished within three years from the date a notice of intention was filed for the subdivision public report; and

(2) Six months have elapsed, without communication from the developer, since the commissioner has given notice of deficiencies or substantive inadequacies contained in the documents which are required to make the filing substantially complete and the deficiencies and inadequacies have not been corrected by the applicant; and

(3) The term of any one-year extension of time in which to complete the application, as provided in subdivision (d), has elapsed.

(b) Ninety (90) days prior to abandoning an application the commissioner shall mail to the applicant and the applicant's designated representative, notice of the commissioner's intent to abandon the application. The notice shall include a statement that the applicant may, in accordance with subdivision (d), file a petition to keep the application open.

(c) Sixty (60) days or more following the mailing of the notice required by subdivision (b), the commissioner may issue a final notice of intention to abandon the application. The application shall be deemed abandoned thirty (30) days after the final notice is mailed to the applicant and the applicant's designated representative, unless, prior to the expiration of the thirty (30) day period, a one-year extension has been granted pursuant to subdivision (d).

(d) The commissioner, on his own motion, or after receipt of a petition from the applicant or the applicant's designated representative, may, under the following terms and conditions, grant a one-year extension in order to allow the applicant to complete the application:

(1) The petition is received prior to the expiration of the thirty (30) day notice period referred to in subdivision (c).

(2) The petition sets forth reasons of hardship or justifiable extenuating circumstances explaining why the file has been inactive. Hardship and justifiable extenuating circumstances shall include mistake, inadvertence, surprise, excusable neglect, or circumstances beyond the control of the applicant or the applicant's designated representative. Written notice of the decision to grant or deny the petition will be mailed or delivered to the applicant and the applicant's designated representative, within thirty (30) calendar days after receipt of the petition.

(e) The commissioner may grant one or more one-year extensions, provided that the application has not been abandoned as provided in subdivision (c).

(f) The term "applicant" as used in this section shall have the same meaning as the term "developer" as used in Section 11212 of the Code.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Sections 11226 and 11234, Business and Professions Code.

HISTORY

1. New section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2810. Filing Fees.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11232, Business and Professions Code.

HISTORY

1. New Article 12.2 (Sections 2810-2813.8) filed 7-17-81; effective thirtieth day thereafter (Register 81, No. 29). For prior history, see Registers 81, No. 21; 80, No. 49; 8, No. 28; 80, No. 3; 75, No. 2; 71, No. 50; 68, No. 9; 59, No. 20; and 55, No. 14.
2. Amendment of subsection (a)(18) filed 1-11-84; effective thirtieth day thereafter (Register 84, No. 2).
3. Repealer of subsections (a)(2) and (a)(3) and subsection renumbering filed 11-27-96; operative 12-27-96 (Register 96, No. 48).
4. New subsection (a)(28) filed 12-30-97; operative 1-29-98 (Register 98, No. 1).
5. New subsections (d)-(d)(3) filed 6-20-2002; operative 7-20-2002 (Register 2002, No. 25).
6. Repealer and new section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).
7. Repealer filed 5-1-2007; operative 5-31-2007 (Register 2007, No. 18).

§ 2810.1. Regulations Applicable to Time-Share Projects.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11000, 11000.1, 11001, 11003.5, 11004.5(e), 11018.5, and 11018.12, Business and Professions Code.

HISTORY

1. Amendment filed 1-11-84; effective thirtieth day thereafter (Register 84, No. 2).
2. Amendment filed 4-2-86; effective thirtieth day thereafter (Register 86, No. 14).
3. Amendment filed 11-16-87; operative 12-16-87 (Register 87, No. 47).
4. Amendment of NOTE filed 5-4-89; operative 6-3-89 (Register 89, No. 23).
5. Amendment of section and NOTE filed 9-29-92; operative 10-30-92 (Register 92, No. 40).
6. Amendment of section and NOTE filed 11-8-93; operative 12-8-93 (Register 93, No. 46).
7. Amendment filed 12-30-97; operative 1-29-98 (Register 98, No. 1).
8. Amendment filed 10-26-99; operative 11-25-99 (Register 99, No. 44).
9. Amendment filed 11-9-2000; operative 12-9-2000 (Register 2000, No. 45).
10. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2810.2. Availability and Suitability for Time-Share Project.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018, 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2810.3. Time-Share Point Systems.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. New section filed 9-5-2003; operative 10-5-2003 (Register 2003, No. 36). For prior history, see Register 2000, No. 45.
2. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2810.4. Addition of Dwelling Units to the Project.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2810.5. Filing Fees.

(a) The filing fees in connection with applications to the Department pursuant to Article 2 of Chapter 2 of Part 2 of the Real Estate Law shall be the following:

(1) One thousand six hundred dollars ($1,600) plus ten dollars ($10) for each time-share interest to be offered for an original public report application.

(2) Five hundred dollars ($500) plus ten dollars ($10) for each time-share interest to be offered that was not permitted to be offered under the public report to be renewed for a renewal public report application.

(3) Three hundred dollars ($300) plus ten dollars ($10) for each time-share interest to be offered under the amended public report for which a fee has not previously been paid for an amended public report application.

(4) Five hundred dollars ($500) for a conditional public report application.

(5) Five hundred dollars ($500) for a preliminary public report application.

(b) The maximum fee for an original, renewal or amended public report shall not exceed $7,500 regardless of the number of interests authorized to be offered for sale or lease.

(c) The filing fee for an amended public report where the amendment consists only of a recurring and non-substantive change including, but not limited to, a change in the name of the developer, shall be $125 and the filing fee for each additional amended public report consisting only of the same recurring and non-substantive change including, but not limited to, a change in the name of the developer, submitted by that developer at the same time, shall be $60. This subsection does not apply where there is a change in the ownership of the time-share property along with a change in the name of the developer.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11232, Business and Professions Code.

HISTORY

1. New section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18). For prior history, see Register 2000, No. 45.
2. Amendment of subsections (a)-(a)(4), new subsection (a)(5), amendment of subsection (b) and repealer and new subsection (c) filed 5-1-2007; operative 5-31-2007 (Register 2007, No. 18).

§ 2810.6. Notification of Material Change.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11012, Business and Professions Code.

HISTORY

1. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2810.7. Alternative Arrangements for Purchaser Protection.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2811. Time-Share Advertising Criteria.

Standards which will be applied by the Real Estate Commissioner in determining whether advertising for sale or lease of time-share interests is false, untrue or misleading within the meaning of those terms in Section 11245 of the Code shall include, but shall not be limited to the following:

(1) Advertising shall not represent the availability for use of a time-share interest that is not set forth in the public report.

(2) A time-share plan shall not be advertised under a name that is not set forth in the application.

(3) A time-share plan shall not be advertised by a name or trade style which implies, contrary to fact, that the developer or his agent is a bona fide research organization, public agency, nonprofit organization or similar entity.

(4) No accommodation, improvement or facility, over which the developer does not have control with respect to completion, may be advertised unless (1) it has been completed (2) completion is assured through bonding or other arrangements approved by the commissioner, or (3) a clear and conspicuous disclosure is included in close proximity to the mention or depiction of the advertised accommodation, improvement or facility stating that the accommodation, improvement or facility is proposed and may not be built.

(5) Reference shall not be made to a proposed public facility or project which purports to affect the value and utility of time-share interests without a disclosure of the existing status of the proposed facility based upon information supplied or verified by the authority responsible for the public facility or project.

(6) Pictorial or illustrative depictions of the time-share property and surrounding lands must accurately portray the land as it exists and proposed improvements as they will be constructed.

(7) Pictorial or illustrative depictions other than unmodified photographs shall bear a prominent disclosure identifying the nature of the depiction, e.g., ARTISTS CONCEPTION and a legend identifying those improvements which are not then in existence.

(8) If a map or diagram is used to show the location of the time-share property in relation to other places, actual miles from each other place to the time-share property shall be shown or the map or diagram shall be prepared to scale and shall include a scale of miles or the map or diagram shall be prominently marked "Not to Scale."

(9) If the existence of a lake, river, canal or other body of water, which is subject to a fluctuating water level other than through natural causes, is advertised as a feature of the time-share property, any significant effect of the fluctuation upon the use of the water facility and upon the time-share interests shall be described.

(10) No advertisement shall imply that a facility is available for the exclusive use of purchasers of time-share interests if a public right of access or of use of the facility exists.

(11) Full disclosure shall be made of the conditions or restrictions upon the availability for use by owners of time-share interests of private clubs or facilities in which an owner will not acquire a proprietary or contractual interest through purchase of a time-share interest, including, if applicable, that the use is at the pleasure of the owner of the facility.

(12) No representation may be made that time-share interests being offered for sale can be further divided unless a full disclosure is included as to the legal requirements for further division of the interests.

(13) Time-share interests may not be advertised as available at a particular minimum price if the number of time-share interests available at that price comprise less than 10% of the unsold inventory of the developer, unless the number of interests then for sale at the minimum price is set forth in the advertisement.

(14) Advertising of a discounted purchase price shall not be made unless the developer has established base prices for application of the discount through a substantial number of sales at base prices.

(15) A prospective increase in the price of a time-share interest may not be implied nor shall a price increase of such a time-share interest be announced without announcing the approximate date on which the increase will be placed into effect, and without a good faith belief that the price increase will be placed into effect on that date.

(16) If the phrase "closing costs only" or similar terminology is used to describe the price of a time-share interest, the estimated dollar amount of the costs must be set forth in the advertisement.

(17) No representation shall be made as to the availability of a resale program offered by or on behalf of the developer, unless the resale program is then in existence and the extent and intended duration of the resale program and any restrictions on the program are fully disclosed to the prospective purchaser.

(18) An asterisk or other reference symbol may be used to explain, but not to contradict or to change the ordinary meaning of the material in the body of the advertisement.

(19) Unless an offer made in connection with a sales promotion is unequivocally without conditions, the terms "free", "no obligation" or similar terms may not be used to describe that which is offered.

(20) Offers of travel, accommodations, meals or entertainment at no cost or reduced cost, the purpose of which is to promote sales, shall not be described as "awards", "prizes" or similar terms.

(21) Offers or solicitations of trip reservations to visit time-share property or any other place where a sales presentation for subdivided property is to be made shall set forth all conditions, limitations or qualifications that will be applied before the recipient will be allowed to make the trip.

(22) The approximate retail value of any gift, prize or premium offered through an advertisement to prospective purchasers shall be set forth in the advertisement. This requirement is limited to gifts, prizes or premiums with a retail value in excess of $25.

(23) Complete rules and procedures for any contest or drawing advertised in connection with the marketing of time-share interests shall be included in the advertisement, or the advertisement shall state the means by which a person can secure full information concerning said rules and procedures prior to his participation in the contest or drawing.

(24) Advertising shall not include testimonials or endorsements which contain matters which the developer would be precluded by law or regulation from making in his own behalf.

(25) An offer or inducement to purchase which purports to be limited as to quantity or restricted as to time shall set forth the numerical quantity and/or time applicable to the offer or inducement.

(26) No direct mail advertisement purporting to have resulted through a referral shall be used unless the developer can, upon request of the commissioner, provide evidence of the referral. Names purchased from marketing lists and similar commercial sources are not considered "referrals" for purposes of this section.

(27) Statements appearing in the public report for a time-share plan shall not be quoted, paraphrased or cited out of context nor shall any part of the public report be underscored, italicized, bold faced or otherwise highlighted except in strict conformance with highlighting in the public report itself.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11245, Business and Professions Code.

HISTORY

1. New subsection (a)(24) filed 6-20-2002; operative 7-20-2002 (Register 2002, No. 25).
2. Repealer and new section filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2812. Reasonable Arrangements in Time-Share Projects.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2812.1. Transfer of Dwelling Units to Association or in Trust.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5-5-2005; operative 7-1-2005 (Register 2005, No. 18).

§ 2812.2. Conveyance of Dwelling Units in Trust.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11013.2, 11013.4, 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.3. Security for Sponsor's Obligations As Owners of Interests.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018(h) and 11018.5, Business and Professions Code.

HISTORY

1. Amendment filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
2. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.4. Subsidization by Sponsor.

NOTE: Authority cited: Section 11001 Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Amendment filed 1–11–84; effective thirtieth day thereafter (Register 84, No. 2).
2. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.5. Covenant Not to Encumber.

NOTE: Authority cited: Section 11001 Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.6. Prohibition Against Partition.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.7. Concurrent Time–Share and Commercial Operation.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.8. Managing Agent Employment.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Amendment of subsection (a)(10) filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
2. Amendment of subsection (a)(10) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
3. Amendment of subsection (a)(10) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
4. Amendment of subsection (a)(3) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
5. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.9. Rental of Occupancy Periods to Public.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.10. Property and Liability Insurance.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Amendment filed 1–11–84; effective thirtieth day thereafter (Register 84, No. 2).
2. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2812.11. Special Procedures for Enforcement of Sponsor's Obligations.

NOTE: Authority cited: Section 11001, Business and Professions Code Section. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. New section filed 1–14–84; effective thirtieth day thereafter (Register 84, No. 2).
2. New subsections (d) and (e) filed 2–1–84; designed effective 2–10–84 pursuant to Government Code Section 11346.2(d) (Register 84, No. 5).
3. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813. Member's Meetings.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Amendment of subsections (e)(1) and (f)(3) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
2. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.1. Members' Voting Rights.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.2. Governing Body Election and Make–Up.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.3. Governing Body Meetings.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.4. Regular and Special Assessments.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.5. Dissemination of Financial and Other Information to Members.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Amendment filed 2–1–84; designated effective 2–10–84 pursuant to Government Code Section 11346.2(d) (Register 84, No. 5).
2. Amendment of subsection (a)(1) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
3. New subsection (c) and subsection relettering filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
4. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.6. Inspection and Copying of Association's Books and Records and Properties.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.7. Disciplining Owners for Violations.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.8. Governing Instruments Amendments.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11018.5, Business and Professions Code.

HISTORY

1. Amendment of subsections (a)–(c) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
2. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.12. Rescission Rights.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 11024, Business and Professions Code.

HISTORY

1. New section filed 9–11–81 as an emergency; effective upon filing (Register 81, No. 39). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–9–82.
2. New section refiled 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
3. Certificate of Compliance as to 9–11–81 order filed 12–01–81 (Register 81, No. 50).
4. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.13. Notice of Rescission Rights.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11024, Business and Professions Code.

HISTORY

1. New section filed 9–11–81 as an emergency; effective upon filing (Register 81, No. 39). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1–9–82.
2. New section refiled 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
3. Certificate of Compliance as to 9–11–81 order filed 12–10–81 (Register 81, No. 50).
4. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
5. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2813.14. Authority of Commissioner to Vary Requirements.

NOTE: Authority cited: Sections 10250.2 and 11001, Business and Professions Code. Reference: Section 10250.2, Business and Professions Code.

HISTORY

1. New section filed 1–10–2001; operative 2–9–2001 (Register 2001, No. 2).
2. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

Article 12.3. Qualified Resort Vacation Club Projects

§ 2814. Applicable Regulations.

A qualified resort vacation club is subject to Sections 2810 and 2810.5.

NOTE: Authority cited: Section 11281, Business and Professions Code. Reference: Section 11232, Business and Professions Code.

HISTORY

1. New article heading and section filed 4–1–93; operative 5–3–93 (Register 93, No. 14). For prior history, see Register 83, No. 30.
2. Amendment filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
3. Amendment filed 10–26–99; operative 11–25–99 (Register 99, No. 44).
4. Amendment of section heading, section and NOTE filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2815. Authority of Commissioner to Vary Requirements of Specified Regulations.

NOTE: Authority cited: Sections 10263 and 11001, Business and Professions Code. Reference: Sections 10260 and 10263, Business and Professions Code.

HISTORY

1. New section filed 4–1–93; operative 5–3–93 (Register 93, No. 14). For prior history, see Register 80, No. 49.
2. Amendment filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
3. Repealer filed 5–5–2005; operative 7–1–2005 (Register 2005, No. 18).

§ 2817. Prospective Purchaser Disclosure Form.

(a) To inform a prospective purchaser of an interest in a qualified resort vacation club of the requirements under Section 10260(e), the notice set forth in subdivision (b) hereof printed in not less than 12–point bold–face capital letters and numerals shall be contained in and immediately follow the face page of every subdivision permit issued for a qualified resort vacation club.

(b) The form and the content of the notice shall be as follows:

NOTICE

IF YOU DECIDE TO PURCHASE AN INTEREST IN THIS QUALIFIED RESORT VACATION CLUB YOU SHOULD BASE YOUR PURCHASE ON THE VALUE OF THE INTEREST AS A VACATION OR LEISURE TIME EXPERIENCE AND NOT AS AN APPRECIATING INVESTMENT OR ON AN EXPECTATION OF RESALE. BEFORE CONTRACTING TO PURCHASE YOU SHOULD CONSIDER THE FOLLOWING:

1. A QUALIFIED RESORT VACATION CLUB PROJECT IS AN OFFERING OF TIME SHARES.

2. AS A GENERAL RULE, A SIGNIFICANT PORTION OF THE PURCHASE PRICE OF AN INTEREST IN A TIME–SHARE PROJECT REPRESENTS THE DEVELOPER'S PROMOTIONAL AND MARKETING COSTS.

3. INDIVIDUAL RESALE OF TIME–SHARE INTERESTS HAVE PROVEN TO BE DIFFICULT FOR OWNERS PRIMARILY BECAUSE TIME–SHARE OWNERS HAVE TO COMPETE WITH HIGHLY SOPHISTICATED SALES PROMOTIONS OF THE DEVELOPER.

4. BECAUSE THE ORIGINAL PURCHASE PRICE REPRESENTS A SIGNIFICANT PART OF THE DEVELOPER'S MARKETING COSTS, A TIME–SHARE OWNER MAY RECOUP ONLY A PORTION OF THE PURCHASE PRICE IF A RESALE BUYER CAN BE FOUND.

5. SINCE MOST TIME–SHARE OWNERS RESIDE SOME DISTANCE FROM THE RESORT OR RESORTS INCLUDED IN THE OFFERING, IT IS USUALLY INCONVENIENT FOR SUCH OWNERS TO SHOW THE DWELLING UNITS TO PROSPECTIVE RESALE BUYERS AND USUALLY THIS CAN ONLY BE DONE DURING THE PERIODS OF USE.

6. LICENSED REAL ESTATE AGENTS HAVE NOT ENTERED INTO THE TIME–SHARE RESALE MARKET IN GREAT NUMBERS, AND THOSE WHO HAVE OFTEN CHARGE A COMMISSION THAT SIGNIFICANTLY EXCEEDS THE NORMAL COMMISSION FOR SALE OF A SINGLE–FAMILY DWELLING.

NOTE: Authority cited: Sections 10263 and 11001, Business and Professions Code. Reference: Section 10260, Business and Professions Code.

HISTORY

1. New section filed 4–1–93; operative 5–3–93 (Register 93, No. 14). For prior history, see Register 83, No. 49.

Article 12.5. Land Projects

§ 2819.5. Definitions.

NOTE: Authority cited for Article 12.5: Section 10080, 10249.2, 10312 and 11001, Business and Professions Code.

HISTORY

1. New Article 12.5 (Sections 2819.5 through 2819.9, 2819.95 and 2819.96) filed 12–12–69, effective thirtieth day thereafter (Register 69, No. 50).
2. Amendment filed 12–10–71; effective thirtieth day thereafter (Register 71, No. 50).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2819.6. Rescission Rights.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11028, Business and Professions Code.

HISTORY

1. Amendment filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2819.7. Disclosure of Rescission Rights.

HISTORY

1. Amendment filed 12–30–70; effective thirtieth thereafter (Register 71, No. 1).
2. Amendment filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2819.8. Cash Deposit Defined.

HISTORY

1. Repealer filed 4–3–73 as an emergency; designed effective 4–5–73. Certificate of Compliance included (Register 73, No. 14).

§ 2819.9. Evidence for Specific Findings.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 11011 and 11025, Business and Professions Code.

HISTORY

1. Repealer and new section filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2819.10. Land Project Treatment Exemption.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 1100.6 and 11028, Business and Professions Code.

HISTORY

1. New section filed 12–27–72; effective thirtieth day thereafter (Register 72, No. 53).
2. Repealer and new NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2819.55. Land Project Subdivision Advertising Criteria.

HISTORY

1. Repealer filed 12–7–73; designated effective thirtieth day thereafter (Register 73, No. 49).

§ 2819.85. Submission of Advertising.

HISTORY

1. New section filed 12–30–70 effective thirtieth day thereafter (Register 71, No. 1).
2. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2819.95. Acceptance for Maintenance Defined.

HISTORY

1. Repealer filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).

§ 2819.96. Report of Withdrawals.

NOTE: Authority cited: Sections 11001 and 11029, Business and Professions Code. Reference: Section 11029, Business and Professions Code.

HISTORY

1. Amendment filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer of section and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 13. Environmental Impact Evaluation

§ 2820. Purpose and Objective.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code and Section 21082, Public Resources Code.

HISTORY

1. Repealer of Article 13 (Sections 2820–2822) and new Article 13 (Sections 2820–2823.1) filed 4–3–73 as an emergency; designated effective 4–5–73. Certificate of Compliance included (Register 73, No. 14). For prior history, see Register 60, No. 1 and Register 68, No. 9.
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2820.1. References and Definitions.

NOTE: Authority cited: Section 11001, Business and Professions Code and Section 21082 Public Resources Code. Reference: Section 21082, Public Resources Code.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2820.2. Discretionary Project Approval.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 21082, Public Resources Code. (Ch. 1335, Statutes of 1980, SB 1777) Business and Professions Code.

HISTORY

1. Amendment filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49).
2. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
3. Amendment filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
4. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2820.3. Application of Environmental Guidelines.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).

2. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2820.4. When "Approval" Occurs.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 21082, Public Resources Code (Ch. 335, Statutes of 1980, SB 1777), Business and Professions Code.

HISTORY

1. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
2. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2821. Local Agency As Lead Agency.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Section 21082 Public Resources Code. (Ch. 1335, Statutes of 1980, SB 1777) Business and Professions Code.

HISTORY

1. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
2. Repealer filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2821.1. Department As Lead Agency.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2821.2. Categorical Exemptions for Amended and Renewal Public Reports.

NOTE: Authority cited: Section 11001, Business and Professions Code, Reference: Section 21082 Public Resources Code. (Ch. 1335, Statutes of 1980, SB 1777) Business and Professions Code.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2822. Submission of Environmental Documentation.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 21082, 21084 and 21086, Public Resources Code.

HISTORY

1. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2822.1. Initial Study.

NOTE: Authority cited: Section 11001, Business and Professions Code. Reference: Sections 21082, 21082.1, Public Resources Code.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
4. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
5. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2822.2. Preparation and Distribution of Draft Environmental Impact Report.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
3. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
4. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2822.3. Hearing Procedure.

HISTORY

1. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2822.4. Preparation and Distribution of Negative Declaration.

HISTORY

1. New section filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2823. Environmental Impact Report Coverage.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2823.1. Fees.

HISTORY

1. Amendment filed 1–16–74; effective thirtieth day thereafter (Register 74, No. 3).
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Repealer filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

Article 14. Mineral, Oil and Gas Transactions

§ 2825. Application for Permit.

HISTORY

1. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2825.5. Salesperson Permittee.

NOTE: Authority cited: Section 11080 Business and Professions Code. Reference: Section 10507, Business and Professions Code.

HISTORY

1. New section filed 7–1–59; effective thirtieth day thereafter (Register 59, No. 11).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2826. Limitation on Number.

HISTORY

1. Amendment filed 10–16–58; effective thirtieth day thereafter (Register 58, No. 19).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2827. Expiration Date.

HISTORY

1. Amendment filed 10–16–58; effective thirtieth day thereafter (Register 58, No. 19).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2828. Transactions to Be Reported.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code.

HISTORY

1. New Section filed 4–3–73 as an emergency; designated effective 4–5–73 (Register 73, No. 14).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2828.1. Filing Reports of Mineral, Oil and Gas Transactions.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10500 and 10513, Business and Professions Code.

HISTORY

1. New section filed 4–3–73 as an emergency; designated effective 4–5–73 (Register 73, No. 14).

2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

3. Repealer filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).

§ 2828.2. Type of Report.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code. Reference: Section 10500, Business and Professions Code.

HISTORY

1. New section filed 4–3–73 as an emergency; designated effective 4–5–73 (Register 73, No. 14).

2. Repealer filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).

Article 15. Trust Fund Accounts

§ 2830. Trust Fund Account.

NOTE: Authority cited: Sections 10080 and 10145(f), Business and Professions Code. Reference: Section 10145, Business and Professions Code.

HISTORY

1. Repealer and new section filed 1–17–80, effective thirtieth day thereafter (Register 80, No. 3). For prior history, see Register 68, No. 39.

2. Amendment filed 2–26–85; effective thirtieth day thereafter (Register 85, No. 9).

3. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2830.1. Interest Bearing Trust Account.

A real estate broker, when acting as agent for a financial institution as beneficiary of a loan, may deposit and maintain funds from or for the account of an obligor for the future payment of property taxes, assessments or insurance relating to real property containing only a one–to–four family residence, in an interest–bearing trust account in a bank or savings and loan association in order to pay interest to the obligor in accordance with Section 2954.8 of the Civil Code if the following requirements are met:

(a) The account is in the name of the broker as trustee.

(b) All of the funds in the account are covered by insurance provided by an agency of the federal government.

(c) All of the funds in the account are funds held in trust by the broker for others.

(d) The broker discloses to the obligor how interest will be calculated and paid.

(e) No interest earned on the funds shall inure directly or indirectly to the benefit of the broker nor to any person licensed to the broker.

NOTE: Authority cited: Section 10081, Business and Professions Code. Reference: Section 10145, Business and Professions Code; and Section 2954.8, Civil Code.

HISTORY

1. New section filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).

2. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).

3. Repealer and new section filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).

§ 2831. Trust Fund Records to Be Maintained.

(a) Every broker shall keep a record of all trust funds received, including uncashed checks held pursuant to instructions of his or her principal. This record, including records maintained under an automated data processing system, shall set forth in chronological sequence the following information in columnar form:

(1) Date trust funds received.

(2) From whom trust funds received.

(3) Amount received.

(4) With respect to funds deposited in an account, date of said deposit.

(5) With respect to trust funds previously deposited to an account, check number and date of related disbursement.

(6) With respect to trust funds not deposited in an account, identity of other depository and date funds were forwarded.

(7) Daily balance of said account.

(b) For each bank account which contains trust funds, a record of all trust funds received and disbursed shall be maintained in accordance with subdivision (a) or (c).

(c) Maintenance of journals of account cash receipts and disbursements, or similar records, or automated data processing systems, including computer systems and electronic storage and manipulation of information and documents, in accordance with generally accepted accounting principles, shall constitute compliance with subdivision (a) provided that such journals, records, or systems contain the elements required by subdivision (a) and that such elements are maintained in a format that will readily enable tracing and reconciliation in accordance with Section 2831.2.

(d) Nothing in this section shall be construed to permit a violation of Section 10145 of the Code.

(e) A broker is not required to keep records pursuant to this section of checks which are written by a principal, given to the broker and made payable to third parties for the provision of services, including but not limited to escrow, credit and appraisal services, when the total amount of such checks for any transaction from that principal does not exceed $1,000. Upon request of the Department or the maker of such checks, a broker shall account for the receipt and distribution of such checks. A broker shall retain for three years copies of receipts issued or obtained in connection with the receipt and distribution of such checks.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10145 and 10148, Business and Professions Code.

HISTORY

1. Amendment filed 10–16–58; effective thirtieth day thereafter (Register 58, No. 19).
2. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
3. Amendment filed 7–9–80; designated effective thirtieth day thereafter (Register 80, No. 28).
4. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
5. Amendment of subsection (a) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
6. Amendment of subsection (a) filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
7. New subsections (b) and (d), subsection relettering, and amendment of subsections (a)–(a)(7) and newly designated subsection (c) filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
8. Amendment of subsection (c) and new subsection (e) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
9. Amendment of subsections (b)–(e) filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2831.1. Separate Record for Each Beneficiary or Transaction.

(a) A broker shall keep a separate record for each beneficiary or transaction, accounting for all funds which have been deposited to the broker's trust bank account and interest, if any, earned on the funds on deposit. This record shall include information sufficient to identify the transaction and the parties to the transaction. Each record shall set forth in chronological sequence the following information in columnar form:

(1) Date of deposit.

(2) Amount of deposit.

(3) Date of each related disbursement.

(4) Check number of each related disbursement.

(5) Amount of each related disbursement.

(6) If applicable, dates and amounts of interest earned and credited to the account.

(7) Balance after posting transactions on any date.

(b) Maintenance of trust ledgers of separate beneficiaries or transactions, or similar records, or automated data processing systems, including computer systems and electronic storage and manipulation of information and documents, in accordance with generally accepted accounting principles will constitute compliance with subdivision (a), provided that such ledgers, records, or systems contain the elements required by subdivision (a) and that such elements are maintained in a format that will readily enable tracing and reconciliation in accordance with Section 2831.2.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10145 and 10148, Business and Professions Code.

HISTORY

1. New section filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
2. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
5. Amendment of subsection (a) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
6. Amendment of subsection (b) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
7. Amendment of subsection (b) and NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2831.2. Trust Account Reconciliation.

The balance of all separate beneficiary or transaction records maintained pursuant to the provisions of Section 2831.1 must be reconciled with the record of all trust funds received and disbursed required by Section 2831, at least once a month, except in those months when the bank account did not have any activities. A record of the reconciliation must be maintained, and it must identify the bank account name and number, the date of the reconciliation, the account number or name of the principals or beneficiaries or transactions, and the trust fund liabilities of the broker to each of the principals, beneficiaries or transactions.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10145, Business and Professions Code.

HISTORY

1. New section filed 3–18–88; operative 4–17–88 (Register 88, No. 14).

§ 2832. Trust Fund Handling.

(a) Compliance with Section 10145 of the Code requires that the broker place funds accepted on behalf of another into the hands of the owner of the funds, into a neutral escrow depository or into a trust fund account in the name of the broker, or in a fictitious name if the broker is the holder of a license bearing such fictitious name, as trustee at a bank or other financial institution not later than three business days following receipt of the funds by the broker or by the broker's salesperson.

(b) Except as expressly provided by subdivision (d) of Section 10145 of the Code or by a regulation in this article, the account into which the trust funds are deposited shall not be an interest-bearing account for which prior written notice can by law or regulation be required by the financial institution as a condition to the withdrawal of funds.

(c) A check received from the offeror may be held uncashed by the broker until acceptance of the offer if

(1) the check by its terms is not negotiable by the broker or if the offeror has given written instructions that the check shall not be deposited nor cashed until acceptance of the offer and

(2) the offeree is informed that the check is being so held before or at the time the offer is presented for acceptance.

(d) In these circumstances if the offeror's check was held by the broker in accordance with subdivision (c) until acceptance of the offer, the check shall be placed into a neutral escrow depository or the trust fund account, or into the hands of the offeree if offeror and offeree expressly so provide in writing, not later than three business days following acceptance of the offer unless the broker receives written authorization from the offeree to continue to hold the check.

(e) Notwithstanding the provisions of subdivisions (a) and (d), a real estate broker who is not licensed under the Escrow Law (Section 17000, et seq., of the Financial Code) when acting in the capacity of an escrow holder in a real estate purchase and sale, exchange or loan transaction in which the broker is performing acts for which a real estate license is required shall place all funds accepted on behalf of another into the hands of the owner of the funds, into a neutral escrow depository or into a trust fund account in the name of the broker, or in a fictitious name if the broker is the holder of a license bearing such fictitious name, as trustee at a bank or other financial institution not later than the next business day following receipt of the funds by the broker or by the broker's salesperson.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10145, Business and Professions Code.

HISTORY

1. Amendment filed 10–16–58; effective thirtieth day thereafter (Register 58, No. 19).
2. Amendment filed 7–16–64; effective thirtieth day thereafter (Register 64, No. 15).
3. Amendment filed 9–17–65; designated effective 1–2–66 (Register 65, No. 17).
4. Amendment filed 12–27–72; effective thirtieth day thereafter (Register 72, No. 53).
5. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
6. Amendment of subsection (a) and repealer and new subsection (b) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
7. Amendment of subsection (d), new subsection (e) and amendment of NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
8. Amendment of subsections (a) and (e) filed 7–31–98; operative 8–30–98 (Register 98, No. 31).

§ 2832.1. Trust Fund Handling for Multiple Beneficiaries.

The written consent of every principal who is an owner of the funds in the account shall be obtained by a real estate broker prior to each disbursement if such a disbursement will reduce the balance of funds in the account to an amount less than the existing aggregate trust fund liability of the broker to all owners of the funds.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10145, Business and Professions Code.

HISTORY

1. New section filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49). For history of former section, see Register 72, No. 53.
2. Amendment of section and NOTE filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
3. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2833. Unexplained Trust Account Overages.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10145 and 10148, Business and Professions Code.

HISTORY

1. New section filed 12–14–51; effective thirtieth day thereafter (Register 26, No. 6).
2. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
3. Repealer filed 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
4. New section with new heading filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
5. Repealer of section and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2834. Trust Account Withdrawals.

(a) Withdrawals may be made from a trust fund account of an individual broker only upon the signature of the broker or one or more of the following persons if specifically authorized in writing by the broker:

(1) a salesperson licensed to the broker.

(2) a person licensed as a broker who has entered into a written agreement pursuant to section 2726 with the broker.

(3) an unlicensed employee of the broker with fidelity bond coverage at least equal to the maximum amount of the trust funds to which the employee has access at any time.

(b) Withdrawals may be made from the trust fund account of a corporate broker only upon the signature of:

(1) an officer through whom the corporation is licensed pursuant to section 10158 or 10211 of the Code; or

(2) one of the persons enumerated in paragraph (1), (2) or (3) of subdivision (a) above, provided that specific authorization in writing is given by the officer through whom the corporation is licensed and that the officer is an authorized signatory of the trust fund account..

(c) An arrangement under which a person enumerated in paragraph (1), (2) or (3) of subdivision (a) above is authorized to make withdrawals from a trust fund account of a broker shall not relieve an individual broker, or the broker–officer of a corporate broker licensee, from responsibility or liability as provided by law in handling trust funds in the broker's custody.

NOTE: Authority cited: Section 1008, Business and Professions Code. Reference: Section 10145, Business and Professions Code.

HISTORY

1. New section filed 5–16–57; effective thirtieth day thereafter (Register 57, No. 8).
2. Amendment filed 1–31–58; effective thirtieth day thereafter (Register 58, No. 2).
3. Amendment filed 7–16–64; effective thirtieth day thereafter (Register 64, No. 15).
4. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
5. Amendment filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
6. Amendment of subsections (a), (b) and (c) filed 7–12–91; operative 8– 11–91 (Register 91, No. 44).
7. Amendment of subsection (b) and newly designated subsections (b)(1) and (b)(2), and amendment of NOTE filed 11–8–93; operative 12–8–93 (Register 93, No. 46).

§ 2835. Commingling.

"Commingling" as used in Section 10176(e) of the Code is prohibited except as specified in this section. For purposes of Section 10176(e), the following shall not constitute "commingling":

(a) The deposit into a trust account of reasonably sufficient funds, not to exceed $200, to pay service charges or fees levied or assessed against the account by the bank or financial institution where the account is maintained.

(b) The deposit into a trust account maintained in compliance with subdivision (d) of funds belonging in part to the broker's principal and in part to the broker when it is not reasonably practicable to separate such funds, provided the part of the funds belonging to the broker is disbursed not later than twenty–five days after their deposit and there is no dispute between the broker and the broker's principal as to the broker's portion of the funds. When the right of a broker to receive a portion of trust funds is disputed by the broker's principal, the disputed portion shall not be withdrawn until the dispute is finally settled.

(c) The deposit into a trust account of broker owned funds in connection with activities pursuant to either subdivision (d) or (e) of Section 10131 of the Code or when making, collecting payments or servicing a loan which is subject to the provisions of Section 10240 of the Code provided:

(1) The broker meets the criteria of Section 10232 of the Code.

(2) All funds in the account which are owned by the broker are identified at all times in a separate record which is distinct from any separate record maintained for a beneficiary.

(3) All broker owned funds deposited into the account are disbursed from the account not later than 25 days after their deposit.

(4) The funds are deposited and maintained in compliance with subdivision (d).

(5) For the purpose of this section, a broker shall be deemed to be subject to the provisions of Section 10240 of the Code if the broker delivers the statement to the borrower required by Section 10240.

(d) The trust fund account into which the funds are deposited is maintained in accordance with the provisions of Section 10145 and the regulations of this article.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10176, Business and Professions Code.

HISTORY

1. New section filed 4–1–93; operative 5–3–93 (Register 93, No. 14). For prior history, see Register 83, No. 30.
2. Amendment of subsection (a) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
3. Amendment of subsection (d) filed 3–17–2005; operative 4–16–2005 (Register 2005, No. 11).

§ 2836. Subdivider and Broker Records.

(a)(1) A subdivider shall maintain or cause to be maintained, in accordance with accepted accounting practices, records of all funds received from prospective purchasers or lessees of subdivisions interests.

(2) A subdivider shall maintain or cause to be maintained, in accordance with accepted accounting practices, records of receipt, deposit and disbursement of all funds collected or obtained in connection with the operation of a homeowners association

(3) The records shall reflect dates of receipt and disbursement of funds and the names of persons from whom received and to whom disbursed. The records shall be retained by the subdivider for a period of three years after the date of receipt or disbursement.

(b) A broker shall maintain or cause to be maintained, in accordance with accepted accounting practices, all trust fund records described in Section 10148 of the Code.

(c) Such records shall be made available for examination and inspection in California during regular business hours upon request by the commissioner or his or her designated representative.

NOTE: Authority cited: Sections 10080 and 11001, Business and Professions Code. Reference: Sections 10145, 10148, 11013.2, 11013.4 and 11018.5 Business and Professions Code.

HISTORY

1. New section filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

Article 16. Mortgage Loan Brokerage

§ 2840. Approved Borrower Disclosure Statements.

(a) The Commissioner shall publish and make available to interested persons as official forms of the Department of Real Estate Forms RE 882 (Rev. 1/08) and RE 883 (Rev. 1/08) which are incorporated by reference. Forms RE 882 and RE 883 contain approved format and content for the disclosure statement required by subdivision (a) of Section 10240 of the Code and Section 10241 of the Code.

(b) The publication of the forms pursuant to subdivision (a) hereof is for the purpose of aiding real estate licensees in providing the disclosure of material information to prospective borrowers in a uniform and effective manner and to assist them in meeting some of the disclosure objectives in Section 10240.3 of the Code.

(c) A real estate broker must obtain the prior written approval of the Commissioner if he/she wishes to use forms different than those referred to in (a). Forms that do not adequately provide the information required by the forms in subsection (a) above, as appropriate, and in a format that is easily used by the Department will not be approved.

NOTE: Authority cited: Sections 10080 and 10240.3, Business and Professions Code. Reference: Sections 10240, 10240.3 and 10241, Business and Professions Code.

HISTORY

1. Amendment filed 11–19–69; designated effective 1–2–70 (Register 69, No. 47). For prior history, see Register 63, No. 14.
2. Repealer and new section filed 4–17–73 as an emergency; designated effective 4–18–73. Certificate of Compliance included (Register 73, No. 16).
3. Amendment filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50).
4. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
5. Amendment filed 2–17–83; designated effective 2–20–83 pursuant to Government Code Section 11346.2(d) (Register 83, No. 8).
6. Amendment of subsection (a) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
7. Amendment filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
8. Amendment filed 7–12–91; operative 8–11–91 (Register 91, No. 44).

9. Amendment of subsections (a)–(c) filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
10. Amendment of subsection (b) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
11. Amendment of subsection (a) filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
12. Amendment of section and NOTE filed 3–17–2005; operative 4–16–2005 (Register 2005, No. 11).
13. Amendment of section heading, repealer and new section and amendment of NOTE filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35).
14. Amendment of section and NOTE filed 1–14–2008 as an emergency; operative 1–14–2008 (Register 2008, No. 3). A Certificate of Compliance must be transmitted to OAL by 7–14–2008 or emergency language will be repealed by operation of law on the following day.

§ 2840.1. Alternative Approved Borrower Disclosure Statement. [Repealed]

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10236.4, 10240, 10240.2 and 10241, Business and Professions Code.

HISTORY

1. New section filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
2. New subsection (d) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
3. Amendment of section and NOTE filed 3–17–2005; operative 4–16–2005 (Register 2005, No. 11).
4. Repealer filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35).

§ 2841. Mortgage Loan Negotiation.

(a) The term "negotiation" as used in Section 10133.1(c) of the Code does not include any of the limited activities described as follows when done by an employee of a real estate broker under the control, direction and supervision of the broker:

(1) Preparing and designing advertising relating to loan transactions for broker review and written approval prior to its distribution, circulation, use or publication.

(2) Distributing, circulating, using or publishing preprinted brochures, flyers, fact sheets or other written materials relating to loans secured by real property which the broker can make or negotiate and which have been reviewed and approved in writing by the broker prior to their being distributed, circulated or published. Materials subject to this subdivision may not contain the name, address or telephone number of the nonlicensed employee.

(3) Providing written factual information about loan terms, conditions or qualification requirements to a prospective borrower that has been either prepared by the broker, or reviewed and approved in writing by the broker. A nonlicensed employee may discuss such information with a prospective borrower in general terms, but may not provide counseling or advice to a prospective borrower.

(4) Notifying a prospective borrower of the information needed in order to complete a loan application without providing counseling or advice to a prospective borrower.

(5) Entering information provided by the prospective borrower on a pre–printed application form without providing counseling or advice to a prospective borrower.

(6) Entering information provided by a prospective borrower or third party into a preformatted computer database.

(7) Accepting and providing a receipt on behalf of a broker for funds received from a prospective borrower for credit or appraisal fees.

(8) Preparing and mailing requests for verification of employment, verification of deposits, credit reports or appraisal reports. Obtaining such reports for transmission to the broker.

(9) Assembling, under the direction of the broker, materials obtained in the course of a loan transaction for submission to a prospective lender or loan committee, providing the final determination as to completeness or compliance is made by the broker.

(10) Communicating with a service provider in connection with a loan transaction to determine when reports or other information needed concerning any aspect of the transaction will be delivered, or when certain services will be performed or completed.

(11) Mailing, delivering, picking up, or arranging the mailing, delivery, or picking up of documents or instruments related to the loan transaction, including obtaining signatures to the documents or instruments from principals, parties or service providers in connection with the loan transaction, as long as the nonlicensed employee does not interpret or explain the content, relevance, significance or effect of the document or signature and such documents or instruments have been reviewed and approved in writing by the broker.

(12) Contacting a prospective lender to determine the status of a loan application.

(13) Responding to an inquiry or notifying a prospective borrower or his or her agent of the status of the loan application as long as the nonlicensed employee does not interpret or explain the relevance, significance or effect of that status. A nonlicensed employee may communicate omissions to a party or principal to the loan as long as the nonlicensed employee does not interpret or explain the relevance or significance of those omissions.

(14) Preparing and completing documents and instruments under the supervision and direction of the broker if the final documents or instruments will be or have been reviewed and approved in writing by the broker.

(15) Arranging or making appointments for third party service providers to enter the real property securing the loan, or arranging or making appointments for the prospective borrower or lender to meet with the broker, lender or other party or service provider in connection with the loan.

(b) As used in this section the terms "loan" or "loan transaction" mean a loan secured directly or collaterally by a lien on real property which is a residential mortgage loan transaction, as defined in Section 50003 of the Financial Code and where the lender is an institutional lender, as defined in Section 50003 of the Financial Code. Other than the acts specifically authorized by this Section, at no time may the nonlicensed employee perform any acts for which a real estate license is required within the meaning of Section 10131(d) of the Business and Professions Code.

(c) As used in this Section and in Section 10133.1(c) of the Code the term "employee" means a person in the service of a broker under any appointment or contract of hire, express or implied, oral or written and for whom the broker is obligated to withhold income tax payments and provide workers compensation insurance and unemployment insurance.

(d) As used in this Section, the term "written approval" shall consist of the broker's signature or initials affixed by the broker to a copy of the instrument being approved along with the date of the approval. The broker shall retain a copy of the approval for a period of three years from the date the approval was made. A broker may delegate to a broker or salesperson employed by the broker the authority to provide written approval so long as the broker does not relinquish overall responsibility for supervision of nonlicensed persons acting under this Section.

NOTE: Authority cited: Sections 10080 and 10133.1, Business and Professions Code. Reference: Section 10133.1, Business and Professions Code.

HISTORY

1. New section filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45). For prior history, see Register 96, No. 46.

§ 2841.5. Recordation of Trust Deeds — Multi–Lender Loans.

A real estate licensee who negotiates a promissory note secured by a trust deed on real property pursuant to Section 10238 of the Code shall cause the trust deed to be executed naming as beneficiaries the lenders or their nominee (who shall not be the licensee or the licensee's nominee) and shall cause the trust deed to be recorded, with the county recorder of the county in which the real property is located prior to the time that any funds are disbursed, except when the lender has given written authorization for prior release. If funds are released on the lenders' written authorization, the trust deed shall be recorded, or delivered to the lenders or beneficiaries with a written recommendation that it be recorded forthwith, within 10 days following release.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10238, Business and Professions Code.

HISTORY

1. New section filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2842. Approved Borrower Disclosure Statement for Nontraditional and Subprime Mortgage Products.

(a) Notwithstanding Section 2840 of these regulations, the Commissioner shall publish and make available to interested persons as an official form of the Department of Real Estate Form RE 885 (Rev. 1/08) which is incorporated by reference, with approved format and content for the disclosure statement referred to in subdivision (a) of Section 10240 of the Code and Section 10241 of the Code.

(b) The publication of the form pursuant to subdivision (a) hereof is for the purpose of aiding real estate licensees in providing the disclosure of material information in a uniform and effective manner to prospective home loan borrowers (1) whose loans involve a "nontraditional mortgage product" as that term is defined in subsection (c) below, and/or (2) who are not able to qualify for prime loan products due to credit characteristics indicating a higher risk of default.

(c) For the purpose of this regulation, a "nontraditional mortgage product" is a loan that allows borrowers to defer repayment of principal or interest. Such products include, but are not limited to, interest only loans where a borrower pays no loan principal for a period of time and payment option loans where one or more of the payment options may result in negative amortization.

A "nontraditional mortgage product" does not include reverse mortgages or home equity lines of credit (other than simultaneous second lien loans).

(d) A real estate broker must obtain the prior written approval of the Commissioner if he/she wishes to use a form different than that referred to in subsection (a) above with a nontraditional mortgage product. Forms that do not adequately provide the information required by Sections 10240 and/or 10241 of the Code, as appropriate, and in a format that is easily used by the Department, will not be approved.

NOTE: Authority cited: Sections 10080 and 10240.3, Business and Professions Code. Reference: Sections 10236.4, 10240, 10240.2, 10240.3 and 10241, Business and Professions Code.

HISTORY

1. New section filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35). For prior history, see Register 61, No. 15.
2. Amendment of section heading, subsections (a) and (b) and NOTE filed 1–14–2008 as an emergency; operative 1–14–2008 (Register 2008, No. 3). A Certificate of Compliance must be transmitted to OAL by 7–14–2008 or emergency language will be repealed by operation of law on the following day.

§ 2842.5. Signing Mortgage Loan Disclosure Statement.

For purposes of Section 10240 of the Code a loan application shall be considered complete when the licensee receives or has prepared a written application on an application form or forms normally used by the lender for a Federally Related Mortgage Loan, and as to non–federally related mortgage loans, when the licensee receives or has prepared a written application on an application form or forms normally used by a lender or the licensee.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10240 and 10241, Business and Professions Code.

HISTORY

1. Amendment filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50). For prior history, see Register 61, No. 15.
2. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
4. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2842.7. Costs and Expenses to Be Shown on Mortgage Loan Broker's Statement.

HISTORY

1. New section filed 12–16–58; effective thirtieth day thereafter (Register 58, No. 23).
2. Repealer filed 7–5–61 as an emergency; effective on filing (Register 61, No. 13).
3. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).

§ 2843. Restrictions on Chargeable Costs and Expenses.

No "costs and expenses of making the loan" referred to in Section 10241(a) which have not been paid, incurred or reasonably earned by the loan broker shall be charged to the borrower. No fee may be charged to a borrower as part of the costs and expenses of making the loan which exceeds the fee customarily charged for the same or comparable service in the community where the service was rendered.

If the escrow depositary for a loan transaction is a licensed escrow agent, a title insurance company, a bank or trust company or a savings and loan association, and a fee is charged to the borrower by the escrow depositary for the escrow function, no additional fee may be charged by the broker, a salesperson licensed to the broker or any entity controlled by the broker for services related to the conduct of an escrow.

NOTE: Additional authority cited: Section 10248.9, Business and Professions Code. Reference: Sections 10241 and 10241.1, Business and Professions Code.

HISTORY

1. Amendment filed 11–19–69; designated effective 1–2–70 (Register 69, No. 47). For prior history, see Register 61, No. 15.
2. Amendment filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50).
3. Amendment of section and NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2844. Lending Practices for Nontraditional and Subprime Mortgage Products.

(a) A real estate broker acting within the meaning of Section 10131.1 of the Code shall adopt and adhere to the policies and procedures set forth in the guidance on nontraditional mortgage product risks published on November 14, 2006, by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators, and the Statement on Subprime Mortgage Lending published on July 17, 2007, by the aforementioned entities and the National Association of Consumer Credit Administrators, and which are incorporated by reference.

(b) Pursuant to subdivision (a), a real estate broker shall, at a minimum, adopt and adhere to the following:

(1) Risk Management Practices

(A) Consider a borrower's ability to repay the mortgage loan according to its terms as the primary basis for making the loan rather than the foreclosure or liquidation value of the collateral.

(B) Ensure that a loan results in an identifiable benefit to the borrower and refrain from inducing a borrower to repeatedly refinance a loan in order to charge high points and fees each time the loan is refinanced.

(C) Fully disclose the true nature of the mortgage loan obligation, or ancillary products to the borrower.

(2) Underwriting Standards

(A) Analyze a borrower's repayment capacity to include an evaluation of his/her ability to repay the loan by final maturity at the fully indexed rate, assuming a fully amortizing repayment schedule. For products that permit negative amortization, a repayment analysis should be based on the initial loan amount plus any balance increase that may accrue from the negative amortization.

(B) Avoid combining nontraditional loan features such as interest–only or negative amortization loans with reduced documentation or simultaneous second–lien loans (piggyback) unless there are mitigating factors such as high credit scores, low loan to value ratios (LTVs) and debt to income ratios (DTI), significant liquid assets, mortgage insurance or other credit enhancements.

(C) Accept stated income or reduced documentation only if there are mitigating factors that clearly minimize the need for direct verification of the borrower's repayment. The mitigating factors shall be documented.

(D) When setting introductory rates on adjustable rate mortgages, consider the spread between the introductory rate and the fully indexed rate to minimize negative amortization, payment shock and earlier–than–scheduled recasting of monthly payments.

(E) When making loans to borrowers categorized as "subprime", ensure that such programs do not feature terms that could become predatory or abusive as described in the "Statement on Subprime Mortgage Lending" under "Predatory Lending Considerations" and the "Guidance on

Nontraditional Mortgage Product Risks" under "Lending to Subprime Borrowers".

(F) Qualify borrowers financing non–owner occupied investment properties on their ability to service the debt over the life of the loan and require evidence that the borrower has sufficient cash reserves to service the loan considering the possibility of extended periods of property vacancy and the variability of debt service requirements associated with nontraditional mortgage loan products.

(G) Qualify a borrower's repayment capacity by a debt–to–income (DTI) ratio that includes an assessment of the borrower's total monthly housing–related payments (e.g. principal, interest, taxes and insurance) and total monthly obligations as a percentage of gross income.

(3) Control Systems

(A) Design compensation programs that avoid providing incentives for originations inconsistent with sound underwriting and consumer protection principles. Such programs should not result in the steering of consumers to products resulting in payment shock or containing prepayment penalties, balloon payments or a higher cost due to reduced documentation or stated income, to the exclusion of other products for which the consumer may qualify.

(B) Monitor the quality of third–party originations so that they reflect the broker's lending standards and compliance with the Real Estate Law, Regulations of the Real Estate Commissioner and other applicable state and federal laws and regulations.

(4) Consumer Protection

(A) Approve loans based on the borrower's ability to repay the loan according to its terms.

(B) Assist the consumer in selecting a product by providing information that enables the consumer to understand material terms, costs, and risks of loan products.

(C) When offering mortgage product descriptions and advertisements, provide clear, detailed information about the costs, terms, features, and risks of the loan to the borrower including:

- Potential payment shock
- Negative amortization
- Prepayment penalties
- Balloon payments
- Cost of reduced documentation loans
- Responsibility for taxes and insurance

(D) Provide monthly statements to consumers who have Payment Option adjustable rate mortgages (ARMs) which include information that enables consumers to make informed payment choices, and which include an explanation of each payment option available and the impact of that choice on loan balances.

(E) Avoid leading borrowers who have Payment Option ARMs to select a non–amortizing or negatively amortizing payment.

NOTE: Authority cited: Sections 10080 and 10240.3, Business and Professions Code. Reference: Sections 10131.1, 10240.3 and 10245, Business and Professions Code.

HISTORY

1. New section filed 1–14–2008 as an emergency; operative 1–14–2008 (Register 2008, No. 3). A Certificate of Compliance must be transmitted to OAL by 7–14–2008 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 61, No. 15.

§ 2845. Interpretive Opinion Request.

(a) A request for an interpretive opinion pursuant to Section 10236 of the Code shall be addressed to the Headquarters Office of the Department to the attention of Chief Counsel.

(b) An interpretive opinion request shall satisfy each of the following conditions:

(1) The request shall clearly state that it is a request for an interpretive opinion pursuant to Section 10236 of the Code.

(2) The request shall be addressed to a specific transaction or transactions or to a narrowly–defined course of conduct or business practice. The persons or entities on whose behalf the request is made shall be identified. If the persons or entities cannot be identified by name at the time of the request, they must be identified by their capacities in the transaction, course of conduct, or business practice. If the person requesting the opinion knows of persons other than those on whose behalf the request is made who intend to engage in a transaction, course of conduct, or business practice in reliance upon the opinion, such information shall also be included in the request for opinion.

(3) The nature of the transaction, course of conduct, or business practice, the capacities of parties to the transaction, and relevant details about it shall be described. Instruments, or other documents that will be used in the transaction, course of conduct, or business practice, completed in illustrative form to explain the transaction, course of conduct, or business practice, shall be appended to the request.

(4) The question or questions central to the opinion request shall be specifically and narrowly framed.

(c) Attorneys at law seeking interpretive opinions on behalf of clients shall include with the opinion requests, their own analyses of the issues presented by the request, their views with respect to the issues presented and citations of legal authority in support of those views.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10236, Business and Professions Code.

HISTORY

1. Amendment filed 8–3–66; effective thirtieth day thereafter (Register 66, No. 25). For prior history, see Register 57, No. 20.
2. Repealer and new section filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Repealer and new section filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).

§ 2846. Approved Lender/Purchaser Disclosure Statement.

(a) The commissioner shall publish and make available to interested persons as an official form of the Department of Real Estate, an approved format and content for the disclosure statements referred to in subdivisions (a) and (b) of Section 10232.5 of the Code.

(b) The publication of a form pursuant to subdivision (a) hereof is for the purpose of aiding real estate licensees in providing information of significance to prospective lenders and purchasers of promissory notes secured by real property and real property sales contracts in a uniform and

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effective manner. The form shall not constitute the only format or prescribed content that will satisfy the requirements of Section 10232.5 of the Code. The commissioner will entertain requests for approval of a proposed disclosure statement not in conformance with the form published pursuant to subdivision (a) only from persons who have established to the satisfaction of the commissioner that the request for approval is made on behalf of 25 or more real estate brokers who are subject to subdivision (e) of Section 10232 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10232.4 and 10232.5, Business and Professions Code.

HISTORY

1. Repealer filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
2. New section filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20). For prior history, see Register 61, No. 15.

§ 2846.1. Material Change—Multi-Lender Loans.

A material change requiring an amended notice under Section 10238(a) of the Code shall include but shall not be limited to the following:

(a) A change of the month in which the broker's fiscal year ends.

(b) A change with respect to whether the broker is (or expects to be) required to file reports of inspection of its trust account(s) with the Real Estate Commissioner pursuant to paragraph (3) of subdivision (k) of Section 10238 of the Code.

(c) A change with respect to the identity of the Servicing Agent.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10238, Business and Professions Code.

HISTORY

1. New section filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).
2. Amendment of first paragraph, subsection (b) and NOTE filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2846.5. Report of Annual Trust Fund Accounts Review.

(a) The annual report of a review of trust fund financial statements required under subdivision (a) of Section 10232.2 and/or subdivision (o) of Section 10238 of the Code shall include confirmation by an independent public accountant that:

(1) The broker maintains those records specified in Sections 2831 and 2831.1 of these regulations, and reconciles such records in accordance with Section 2831.2 of these regulations.

(2) Each trust fund bank account is maintained by the broker in compliance with Sections 2832 and 2834 of these regulations.

(3) The accountant has reviewed the accompanying balance sheet of trust funds held by the broker as of the last day of the fiscal year, and the accompanying statement of receipts and disbursements of trust funds and changes in cash for the fiscal year, in accordance with standards established by the American Institute of Certified Public Accountants.

(4) The accountant is not aware of any material modifications that should be made to the trust fund financial statements in order for them to be in conformity with generally accepted accounting principles.

(5) The adjusted balance(s) of the bank trust account(s) maintained by the broker as shown in the accompanying financial statements were on deposit as of the financial statements date.

(6) The trust fund bank account balance(s) and receipts and disbursements shown on the financial statements agreed with the amounts reflected on the cash records specified in Section 2831 of these regulations.

(7) The trust fund liability balance for each open account as itemized in the financial statements agreed with the amount reflected on the separate beneficiary records specified in Section 2831.1 of these regulations.

(b) In preparing the report referred to in subdivision (a), the accountant may incorporate qualifying representations or disclaimers substantially as follows:

(1) All information included in the financial statements examined by the accountant are representations of the broker or of responsible officers of the broker.

(2) The review by the accountant consisted principally of inquiries of company personnel and analytical procedures applied to financial data. It was substantially less in scope than an examination in accordance with generally accepted auditing standards, the objective of which is the expression of an opinion regarding the financial statements taken as a whole. The report therefore includes no such opinion.

(c) In lieu of complying with subdivision (a) above, a broker may satisfy subdivision (a) of Section 10232.2 and/or subdivision (o) of Section 10238 of the Code by submitting the report by a California independent public accountant of an audit of the trust fund financial statements of the broker in which the accountant expresses an unqualified opinion that the financial statements fairly present, in conformity with generally accepted accounting principles, (1) the trust fund position of the broker at the end of the fiscal year and (2) a compilation of receipts and disbursements of trust funds for the fiscal year.

(d) The annual report of a review of trust fund financial statements shall include the following financial statements:

(1) Balance sheet of trust funds held by the broker as of the last day of the fiscal year. Each of the trust fund bank accounts shall be identified, either in the balance sheet or in the notes thereto, by name of bank and account number.

(2) Statement of receipts and disbursements of trust funds and changes in cash for the fiscal year.

(3) Schedule of trust fund liability balances showing each open beneficiary account in connection with trust funds received in carrying on the activities described in subdivisions (d) and (e) of Section 10131 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10145, 10232, 10232.2 and 10238, Business and Professions Code.

HISTORY

1. New section filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
2. Amendment of subsection (a) and new subsection (d) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
3. Amendment of subsection (a)(2) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
4. Amendment of subsections (a) and (c) and NOTE filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2846.7. Delayed Filing of Annual Trust Account Report.

(a) A real estate broker whose fiscal year ends between the last day of November and the last day of February inclusive shall regularly have until the following May 31 in which to file the report required by subdivision (a) of Section 10232.2 or subdivision (o) of Section 10238 of the Code.

(b) A real estate broker whose fiscal year ends between March 1 and November 29 inclusive shall file the report required by subdivision (a) of Section 10232.2 or subdivision (o) of Section 10238 of the Code not later than 90 days after the end of the fiscal year unless the broker shall have previously obtained written authorization from the Department to file the report more than 90 days after the end of the fiscal year.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10232.2 and 10238, Business and Professions Code.

HISTORY

1. New section filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
2. Amendment of section heading, section and NOTE filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
3. Amendment of section and NOTE filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 2846.8. Quarterly Trust Fund Status Report.

(a) The Commissioner shall publish and make available to interested persons as an official form of the Department, an approved format and content for the Trust Fund Status Report described in Section 10232.25 of the Code.

(b) The publication of a form pursuant to subdivision (a) is for the purpose of aiding real estate licensees in complying with Section 10232.25 of the code. The form prescribed by the Commissioner shall not constitute the only format or content that will satisfy the requirements of Section 10232.25.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10232.25, Business and Professions Code.

HISTORY

1. New section filed 1–21–83; effective thirtieth day thereafter (Register 83, No. 4).
2. Repealer of subsection (c) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2847. Voluntary Submission of Proposed Advertising.

(a) A real estate broker may submit for departmental approval advertising proposed to be used in connection with the performance of acts for which a real estate license is required pursuant to Section 10131.1 or subdivision (d) or (e) of Section 10131 of the Code.

(b) Proposed advertising copy shall be submitted to the Sacramento office of the Department. Written or graphic advertising shall be submitted in the format in which it will be displayed to the public. A written script shall be submitted for radio or television advertisements. A submission of advertisement to the Department shall be accompanied by the maximum fee set forth in Section 10232.1 of the Code.

NOTE: Authority cited: Sections 10080 and 10232.1, Business and Professions Code. Reference: Section 10232.1, Business and Professions Code.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective upon filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15). For prior history of section, see Register 61, No. 13).
2. Amendment filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50).
3. Amendment filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
4. Redesignation and amendmenty of first paragraph as new subsection (a), new subsection (b), and amendment of NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2847.1. Advertising Submission and Clearance Procedures.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10232.1, Business and Professions Code.

HISTORY

1. New section filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50).
2. Amendment filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
3. Amendment of subsection (a) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
4. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2847.2. Advertising Identification System.

NOTE: Authority cited: Sections 10080 and 10232.1, Business and Professions Code. Reference: Sections 10232.2 and 10237.7, Business and Professions Code.

HISTORY

1. New section filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50).
2. Repealer and new section filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
3. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
4. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2847.3.

(a) Use of either of the following statements shall satisfy the requirements of Sections 10235.5 and 17539.4 of the Code.

(1) Real estate broker, California Department of Real Estate.

(2) California Department of Real Estate, real estate broker. The words "California" and "Department" may be abbreviated only as "CA" or "CAL" or "Calif" and "Dept". A dash (– –) may be used in lieu of the comma appearing in the statements set forth above in paragraphs (1) and (2).

(b) The type size of the statement as set forth in subdivision (a) will also satisfy the designation requirements of Section 10140.6 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10235.5 and 17539.4, Business and Professions Code.

HISTORY

1. New section filed 4–1–93; operative 5–3–93 (Register 93, No. 14). For prior history, see Register 83, No. 4.

§ 2847.4. Notice to Commissioner.

NOTE: Additional authority cited: Section 10248.9, Business and Professions Code.

HISTORY

1. New section filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50).
2. Repealer filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).

§ 2848. Advertising Criteria.

(a) In administering Sections 10232.1 and 10235 of the Code, the commissioner shall take such action as is appropriate to prevent or halt the publication of advertising that is false, misleading or deceptive in itself or through the omission of information necessary to make a representation not misleading in the context in which it is used. To this end, the commissioner may disapprove or require verification of representations in advertising submitted pursuant to Section 10232.1 of the Code, or Section 2847 of these regulations.

In addition to the actual text, consideration shall be given to such factors as format, pictorial display and emphasis in determining whether an advertisement is likely to create a false impression.

By way of illustration and not of limitation, advertising containing any of the following is considered to be false, misleading or deceptive and will not ordinarily be approved for publication by the commissioner:

(1) The use of "guaranteed," "insured," "bonded," "sure," "safe," "sound" or other words or phrases of similar import to describe or characterize the security of lenders' or purchasers' funds, or the return to lenders or purchasers from the use of their funds, without an accompanying statement of fact supporting the use of the words or phrases implying high security. A representation to the effect that no losses or minimal losses have been sustained by lenders or purchasers doing business with the licensee shall include the period of time to which the representation applies.

(2) The use of terms in the comparative or superlative degree to describe any aspect of the business of the licensee, or any terms applicable to loans negotiated by the licensee, without such additional information as necessary to make the representation unambiguous in the context in which it is used.

(3) A statement that the licensee represents any lender enumerated in Section 10133.1(a) of the Code unless the licensee has a contractual arrangement to act as agent or representative for such lender.

(4) An implication contrary to the fact that the licensee will act in the capacity of a lender rather than as an agent or that a borrower will be able to obtain a loan without deductions from the principal amount for the payment of commissions, costs and expenses customarily attendant upon mortgage loan broker transactions.

(5) A representation of a specific installment in repayment of a loan without an equally prominent disclosure of the following information about the loan:

(A) Principal amount

(B) Simple annual interest rate

(C) Annual percentage rate

(D) Number, amount and period of payments scheduled to the date of maturity

(E) Balance due at maturity (balloon payment) if not fully amortized.

(6) A representation of a specific installment payment, interest rate, annual percentage rate or other provision concerning a loan unless it is clearly indicated whether the advertised terms are available for first loans, junior loans or for both first and junior loans.

(7) A representation or implication that loans are available on terms more favorable to the borrower than terms then generally available in the community through mortgage loan brokers or other sources for loan funds unless the advertised terms are in fact then available to a borrower without the application of undisclosed, special conditions or restrictions to qualify the borrower or the security for the loan.

(8) A representation or implication that loans are available on terms more favorable to the borrower than terms then generally available in the community through mortgage loan brokers or other sources for loan funds unless the broker has previously presented evidence satisfactory to

the commissioner that the advertising is not illusory or deceptive in light of all relevant factors of the broker's business practices including the amount of loan funds prospectively available to meet borrower demands in response to the advertising.

(9) A representation that loans are available at or to a maximum percentage of market value unless there is a disclosure as to how market value will be determined for purposes of a loan transaction.

(10) A representation or implication that the credit rating or other personal financial data of the prospective borrower will not be a factor in determining eligibility for a loan unless the broker in fact neither conducts nor causes to be conducted any investigation or inquiry into any aspect of any prospective borrower's credit rating or into his personal financial circumstances for the purpose of determining his qualifications for a loan.

(11) A representation or implication that a loan can or will be approved by telephone.

(12) A representation implying that the Department or any other governmental agency has endorsed or approved any aspect of the licensee's business activities. A statement that the offering referred to in the advertisement is being made under authority of a permit issued by the Department or by the Department of Corporations without more, will not be considered to be a representation implying endorsement or approval by a governmental entity.

(13) A representation or implication contrary to fact as to the number and location of offices maintained by the licensee for the conduct of his/her mortgage loan brokerage business.

(14) Use of "investment plan," "growth plan," or similar term to describe a program of a licensee carrying on activities described in Section 10131.1.

(15) The use of "savings," "savings plan" or terms of similar import indicating that the licensee is engaged in business activities requiring a particular license, permit or authority unless the licensee then has such a license, permit or authority.

(16) A representation of a simple annual interest rate without an equally prominent disclosure of the annual percentage rate.

(17) A representation of an installment in repayment of an adjustable rate, interest only or payment–option loan without an equally prominent disclosure of the following information about the loan:

(A) Principal amount

(B) Term of loan

(C) Initial interest rate

(D) Number of months the initial interest rate will be in effect

(E) Fully–indexed interest rate

(F) Maximum interest rate

(G) If different, an explanation of the difference between the payment rate, initial interest rate and fully–indexed rate.

(H) Annual percentage rate

(I) How often the interest rate and payments can change

(J) Maximum periodic change in the interest rate and payments (periodic caps)

(K) Number of months and percentage of original loan amount after which minimum payments will not be accepted and the loan re–amortizes

(L) The monthly payment based on the maximum interest rate, and the loan balance after all negative amortization is included, assuming minimum payments are made

(M) If the loan contains a prepayment penalty, a statement to that effect

(N) If the loan contains a balloon payment, a statement to that effect

(18) A statement that the licensee can arrange "low doc/no doc", "no income/no asset", "stated income", "stated asset", "no ratio" or similar loan products without a statement that these products may have a higher interest rate, more points or more fees than other products requiring documentation.

NOTE: Authority cited: Sections 10080 and 10232.1, Business and Professions Code. Reference: Sections 10232.1 and 10235, Business and Professions Code.

HISTORY

1. Amendment filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50). For prior history, see Register 68, No. 39.
2. Amendment filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
3. New subsection (16) filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
4. Editorial correction (Register 95, No. 13).
5. Amendment of section and NOTE filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).
6. New subsections (a)(17) and (a)(18) filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35).

§ 2849. Annual Report Format.

The following format shall be used by a real estate broker who meets the criteria of Section 10232 of the Code for the annual report required by Section 10232.2(c).

MORTGAGE LOAN/TRUST DEED ANNUAL REPORT

(Business and Professions Code Section 10232.2(c))

_____

(Name of Reporting Broker)

_____

_____(Principal Business Office Address)

This report covers mortgage loan brokerage and trust deed and real property sales contract transactions for the period from _____19____, to _____, 19____.

During the reporting period, mortgage loan/trust deed business activities were conducted by the reporting broker and his affiliates at the following address in addition to the principal business address above:

_____

_____

_____

_____

I. LOANS ORIGINATED AS AGENT (Section 10131(d))

	Article 7* Loans	Other Loans
A. Total Loans		
Number	_____	_____
Aggregate Principal Amount	$ _____	$ _____
Commissions Received	$ _____	$ _____
B. Multiple Lender Loans (Fractionalized)**		
Number	_____	_____
Aggregate Principal Amount	$ _____	$ _____
C. Loans to Refinance***Loans Previously Negotiated by Reporting Broker or Affiliate****		
Number	_____	_____
Aggregate Principal Amount	$ _____	$ _____
D. Balloon Payment and Interest–Only Loans		
Number	_____	_____
Aggregate Principal Amount (at maturity)	$ _____	$ _____

II. LOANS ORIGINATED AS PRINCIPAL (FUNDED BY BROKER) FOR RESALE (Section 10131.1)

	Article 7* Loans	Other Loans
A. Total Loans		
Number	_____	_____
Aggregate Principal Amount	$ _____	$ _____
Loan Origination or Other Fees in Lieu of Commission	$ _____	$ _____
B. Loans to Refinance Loans Previously Negotiated By Reporting Broker or Affiliate		
Number	_____	_____
Aggregate Principal Amount	$ _____	$ _____
C. Balloon Payment and Interest–Only Loans Number	_____	_____
Aggregate Principal Amount (at maturity)	$ _____	$ _____
D. Principal (Broker Funded) Loans Resold		
1. Single Purchaser		
a. Number	_____	_____
b. Aggregate Selling Price	$ _____	$ _____
2. Multiple Purchasers (Fractionalized)**		
a. Number	_____	_____
b. Aggregate Selling Price	$ _____	$ _____

III. COSTS AND EXPENSES CHARGED TO BORROWERS IN ORIGINATED LOAN TRANSACTIONS*****

Total	$ _____	$ _____
Retained by Broker or Affiliate for Services	$ _____	$ _____

IV. LOANS FOR BROKER'S USE OR BENEFIT (Section 10231.2)

	All Loans/Sales
Number	_____
Aggregate Amounts Borrowed	$ _____

V. SALES OF NOTES AS AGENT (Section 10131 (e))

Number	_____
Selling Price	$ _____
Commissions Received	$ _____

VI. RESALES AS PRINCIPAL OF NOTES PURCHASED BY BROKER (Section 10131.1)

Number	_____
Aggregate Purchase Price	$ _____
Aggregate Resale Price	$ _____

VII. SALES OF REAL PROPERTY SALES (RPS)CONTRACTS****** AS AGENT OR PRINCIPAL (Sections 10131(e) and 10131.1)

Number	_____
Aggregate Selling Price	$ _____

VIII. NOTE AND RPS CONTRACT SERVICING

A. Number Serviced by Broker or Affiliate	_____
B. Late Charges	$ _____
1. Total Late Charges Paid	$ _____
2. Retained by Broker or Affiliate	$ _____
C. Prepayment Penalties	
1. Number Prepaid	_____
2. Total Paid by Borrowers	$ _____
3. Retained By Broker or Affiliate	$ _____
D. Total Other Charges of Broker or Affiliate for Servicing	$ _____
E. Notice of Default Filed	_____
F. Trustee's Sale, Judicial Sales or Deeds in Lieu of Foreclosure Recorde	_____

To the best of knowledge and belief the information contained in this report is true and correct.

Date: _____ _____
Signature

License No. _____

* Article 7 loans are loans of less than $20,000 secured by first deeds of trust on dwellings and loans of less than $10,000 secured by junior deeds of trust on dwellings if originated before January 1, 1991; or loans of less than $30,000 secured by first deeds of trust on dwellings and loans of less than $20,000 secured by junior trust deeds on dwellings if originated on or after January 1, 1991.

** Fractionalized loan (sale)—One funded through the issuance of a series of notes of equal priority secured by the same real property, or the sale of undivided interests in a single note secured by the same real property, to two or more persons not otherwise associated.

*** Loan to refinance—A loan funded within 90 days of the maturity date of an existing obligation of the borrower in which 75 percent or more of the proceeds made available to the borrower are applied to pay off the existing obligation.

**** Affiliate—Any entity in which an individual reporting broker or an officer, director or shareholder of a corporate reporting broker has more than a nominal financial interest or from whom the reporting broker receives any form of compensation for the referral of business in connection with the reporting broker's mortgage loan activities.

***** For services enumerated in Section 10241(a) and any other charge made to the borrower.

****** As defined in Section 10029 of the Business and Professions Code.

NOTE: Authority cited: Sections 10080, 10232.2, 10248.9, Business and Professions Code. Reference: Sections 10232, 10232, 10240, 10241, 10245, and 10248.9, Business and Professions Code.

HISTORY

1. New section filed 12–11–73 as an emergency; designated effective 1–1–74. Certificate of Compliance included (Register 73, No. 50). For history of former section, see Register 61, No. 5.
2. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
3. Amendment filed 2–2–76 as an emergency; designated effective 2–15–76 (Register 76, No. 6).
4. Certificate of Compliance filed 3–5–76 (Register 76, No. 10).
5. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
6. Repealer and new section filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
7. Amendment filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
8. Editorial correction of printing errors (Register 91, No. 44).
9. Editorial correction (Register 95, No. 13).

§ 2849.01. Annual Report Format.

For reports submitted to the Department, the following format shall be used by a real estate broker who meets the criteria of section 10232 and/or 10238 of the Code for the annual report required by section 10232.2(c) and 10238(p).

MORTGAGE LOAN/TRUST DEED ANNUAL REPORT
(Business and Professions Code Section 10232.2(c) or 10238(p))

_____

Name of Reporting Broker (Corporation or Individual)

_____

Principal Business Address

This report covers mortgage loan brokerage and trust deed and from (month/day/year) to (month/day/year) real property sales contract transactions for the period from (month, day, year) to (month, day, year).

During the reporting period, mortgage loan/trust deed business activities were conducted by the reporting broker and his affiliates at the following address(es) in addition to the principal business address above:

_____

_____

_____

Report Data	*Article 7[1] Loans*	*Other Loans*
I. LOANS ORIGINATED AS AGENT (B&P Code Section 10131(d)) TOTAL LOANS		
Number	_____	_____
Aggregate Principal Amount	$_____	$_____
Total Commissions Received from All Loans Originated as Agent	$_____	$_____
A. MULTIPLE LENDER LOANS (FRACTIONALIZED)[2]		
1) Total Number of Loans	_____	_____
2) Aggregate Principal Amount	$_____	$_____
3) Aggregate Number of Investors	_____	_____
B. LOANS TO REFINANCE[3] LOANS PREVIOUSLY NEGOTIATED BY REPORTING BROKER OR AFFILIATE[4]		
1) Number	_____	_____
2) Aggregate Principal Amount	$_____	$_____
C. BALLOON PAYMENT AND INTEREST-ONLY LOANS		
1) Number	_____	_____
2) Aggregate Principal Amount	$_____	$_____
D. LOANS COVERED UNDER FINANCIAL CODE SECTION 4970[11]		
1) Number	_____	_____
2) Aggregate Principal Amount	$_____	$_____

	Article 7[1] Loans	*Other Loans*
II. LOANS ORIGINATED AS PRINCIPAL (FUNDED BY BROKER) FOR RESALE (B&P Code Section 10131.1)		
TOTAL LOANS		
Number		
Aggregate Principal Amount	$	$
Loan Origination Fees (Points) of all Loans Originated as Principal Funded for Resale	$	$
A. LOANS TO REFINANCE LOANS PREVIOUSLY NEGOTIATED BY REPORTING BROKER OR AFFILIATE		
1) Number		
2) Aggregate Principal Amount (at maturity)	$	$
B. BALLOON PAYMENT AND INTEREST–ONLY LOANS		
1) Number		
2) Aggregate Principal Amount (at maturity)	$	$
C. PRINCIPAL (BROKER FUNDED) LOANS RESOLD		
1. Single Purchaser		
a) Number		
b) Aggregate Selling Price	$	$
2. Multiple Purchasers (Fractionalized)[2]		
a) Number		
b) Aggregate Selling Price	$	$
c) Aggregate Number of Purchaser		
D. LOANS COVERED UNDER FINANCIAL CODE SECTION 4970[11]		
1) Number		
2) Aggregate Principal Amount	$	$
III. COSTS AND EXPENSES PAID BY BORROWERS TO THE BROKER IN ORIGINATED LOAN TRANSACTIONS[5]		
Total	$	$
Retained by Broker or Affiliate for Services	$	$

IV. LOANS FOR BROKER'S USE OR BENEFIT (B&P Code Section 10231.2)	*All Loans/Sales*
A. Total Number	
B. Number of Fractionalized Loans	
C. Aggregate Amount Borrowed	$

V. SALES OF NOTES AS AGENT (B&P Code Section 10131(e))	
TOTAL LOANS	
A. Number	
B. Aggregate Selling Price	$
C. Commissions Received	$
D. Multi–Lender Sales (Fractionalized)	
1) Number of Loans	
2) Aggregate number of Lenders/Investors	
3) Aggregate Selling Price	$
4) Commissions Received	$

VI. RESALES AS PRINCIPAL OF NOTES PURCHASED BY BROKER (B&P Code Section 10131.1) *All Loans/Sales*

TOTAL LOANS

A. Number .....
B. Aggregate Purchase Price ..... $
C. Aggregate Resale Price ..... $
D. Multi–Lender Resales (Fractionalized)
1) Number of Loans .....
2) Aggregate number of Investors .....
3) Aggregate Selling Price ..... $
4) Commissions Received ..... $

VII. SALES OF REAL PROPERTY SALES (RPS) CONTRACTS [7] AS AGENT OR PRINCIPAL (B&P Code Sections 10131(e) and 10131.1)

A. Number .....
B. Aggregate Selling Price ..... $

VIII. NOTE AND RPS CONTRACT SERVICING

A. Total Number of Notes and/or Contracts Serviced During Reporting Period .....
B. Number of Fractionalized Notes Serviced[10] .....
C. Total Dollar Amount of Payments Collected from the Borrowers During the Reporting Period including Payoffs[8] ..... $
D. Total Dollar Amount of Payments Collected from the Borrowers on Fractionalized Loans during the Reporting Period, including Payoffs[10] ..... $
E. Total Dollar Amount of Loans Serviced[9] ..... $
F. Total Dollar Amount of Fractionalized Loans Serviced[10] ..... $
G. Total Late Charges Received During the Reporting Period ..... $
H. Total Late Charges Retained by Broker ..... $
I. Number of Loans Prepaid ..... $
J. Total Amount of Prepayment Penalties Paid by Borrowers ..... $
K. Total Amount of Prepayment Penalties Retained by Broker ..... $
L. Total Other Broker Charges for Servicing ..... $
M. Number of Notices of Default Filed ..... $
N. Number of Trustee's Sales, Judicial Sales or Deeds in Lieu of Foreclosure Recorded .....

CERTIFICATION

To the best of my knowledge and belief the information contained in this report is true and correct.

SIGNATURE OF BROKER OR DESIGNATED LICENSED OFFICER DATE

PRINTED NAME OF BROKER OR DESIGNATED LICENSED OFFICER LICENSE NUMBER(REPORTING BROKER)

NAME OF CORPORATION BUSINESS TELEPHONE NUMBER

If reporting broker is an individual licensee, he/she must sign this report. If reporting broker is a corporate licensee, the corporation's designated licensed officer must sign this report.

1. ARTICLE 7 LOANS — Loans of less than $30,000 secured by first deeds of trust on dwellings and loans of less than $20,000 secured by junior deeds of trust on dwellings.
2. MULTIPLE LENDER LOAN (FRACTIONALIZED) — A loan funded through the sale of or offer to sell a series of notes secured directly by an interest in the same real property, or the sale of undivided interests in a note secured directly by real property equivalent to a series transaction.
3. LOAN TO REFINANCE — A loan funded within 90 days of the maturity date of an existing obligation of the borrower in which 75 percent or more of the proceeds made available to the borrower are applied to pay off the existing obligation.
4. AFFILIATE — Any entity in which an individual reporting broker or an officer, director or shareholder of a corporate reporting broker has more than a nominal financial interest or from whom the reporting broker receives any form of compensation for the referral of business in connection with the reporting broker's mortgage loan activities. Should the affiliate meet the criteria of Section 10232, a separate report must be compiled and submitted for each entity.
5. COSTS AND EXPENSES — For services enumerated in Section 10241(a) (appraisal fees, escrow fees, title charges, notary fees, recording fees, credit investigation fees) and any other charge made to the borrower. Total amount and amount retained by the broker, an affiliate or subsidiary.
6. A purchase or loan transaction in which the broker directly or indirectly obtained the use or benefit of the funds other than for commissions, fees, costs and expenses.
7. REAL PROPERTY SALES (RPS) CONTRACTS — As defined in Section 10029 of the Business and Professions Code:
"Real property sales contract" as used in this part is an agreement wherein one party agrees to convey title to real property to another party upon the satisfaction of specified conditions set forth in the contract and which does not require conveyance of title within one year from the date of formation of the contract.
8. Includes payments collected on behalf of obligors.
9. Outstanding principal of each note on the last day of the fiscal year or the reporting period including fractionalized (multi–lender) loans.
10. Fractionalized (multi–lender) loans only.
11. Refer to Financial Code Section 4970(a) through (e) for the definition of a covered loan.

NOTE: Authority cited: Sections 10080, 10232 and 10232.2, Business and Professions Code. Reference: Sections 10232, 10232.2, 10236, 10240, 10241 and 10245, Business and Professions Code; and Sections 4970 and 4979, Financial Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Amendment filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
3. Amendment of section and NOTE filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).
4. Amendment of section and NOTE filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).
5. Amendment of section and NOTE filed 8–29–2007; operative 9–28–2007 (Register 2007, No. 35).

§ 2849.1. Reporting Transactions Pending at Close of Fiscal Year.

In preparing the report required by Section 10232.2(c) of the Code, a sale or loan transaction shall be considered as business conducted in the fiscal year in which the escrow for the transaction closed.

NOTE: Authority cited: Section 10081, Business and Professions Code. Reference: Section 10232.2, Business and Professions Code.

HISTORY

1. Repealer and new section filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3). For prior history, see Register 76, No. 3 and 61, No.4.
2. Repealer and new section filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
3. Repealer and new section filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).

§ 2849.2. Recording Trust Deeds or Assignments.

NOTE: Authority cited: Section 10176.2, Business and Professions Code; Sections 3081.095 and 3081.096, Civil Code.

HISTORY

1. New section filed 5–16–60 as a emergency; effective upon filing (Register 60, No. 12).
2. Repealer filed 7–5–61; as an emergency; effective upon filing (Register 61, No. 13). For prior history see Register 61, No. 12.

§ 2849.3. Withdrawing Funds from Escrow.

NOTE: Authority cited: Sections 10176.2 and 11001, Business and Professions Code; Sections 3081.095 and 3081.096, Civil Code.

HISTORY

1. New Sections 2849.3, 2849.4, 2849.5, 2849.6 filed 2–20–61 as an emergency; effective upon filing (Register 61, No. 4)
2. Amendments filed 6–16–61 as an emergency; effective upon filing. Certificate of Compliance—Gov. Code. 11422.1 including (Register 61, No. 12).
3. Repealers of 2849.3, 2849.4, 2849.5 and 2849.6 filed 7–5—61 as an emergency; effective on filing (Register 61. No. 13).
4. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).

§ 2849.4. Notification to Escrow Companies.

§ 2849.5. Record of Discount Broker Transaction.

§ 2849.6. Notice of Intention.

§ 2849.7. Dishonest Dealing Defined.

NOTE: Authority cited: Sections 10176.2 and 11001, Business and Professions Code; Sections 3081.095 and 3081.096, Civil Code. Additional authority cited: Sections 10080, 10237.5 and 10238.1(b), Business and Professions Code.

HISTORY

1. New section filed 2–20–61 as an emergency; effective upon filing (Register 61, No. 4).
2. Amendment filed 6–16–61 as an emergency; effective upon filing. Certificate of Compliance—Gov. Code, Sec.11422.1, included (Register 61. No. 12).
3. Amendment filed 7–31–61 as an emergency; effective on filing (Register 61, No. 13).
4. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
5. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2849.8. Reports of Transactions.

NOTE: Authority cited: Sections 10176.2 and 11001, Business and Professions Code; Sections 3081.095 and 3081.096, Civil Code.

HISTORY

1. New section filed 2–20–61 as an emergency; effective upon filing (Register 61, No. 4).
2. Repealer filed 6–16–61 as an emergency; effective upon filing. Certificate of Compliance—Gov. Code, Sec. 11422.1, included (Register 61, No. 12).

§ 2849.31. Treatment of Funds to Be Reinvested.

HISTORY

1. New section filed 2–20–61 as an emergency; effective upon filing (Register 61, No. 4).
2. Amendment filed 6–16–61 as an emergency; effective upon filing. Certificate of Compliance—Gov. Code, Sec. 11422.1 including (Register 61. No. 12).
3. Repealer filed 7–5–61 as an emergency; effective on filing (Register 61, No. 13).
4. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).

Article 17. Prepaid Rental Listing Services

§ 2850. Prepaid Rental Listing Service License for Real Estate Broker.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10167.3, 10167.6, 10167.7, 10167.10 (Ch. 1051, Statutes of 1980, SB 1564), Business and Professions Code.

HISTORY

1. Repealer and new section filed 1–7–80; effective thirtieth day thereafter (Register 80, No. 3). For prior history, see Registers 68, No. 9; 59, No. 20; and 57, No. 4.
2. Repealer and new section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
3. Editorial amendment of article title (Register 81, No. 7).
4. Repealer filed 10–26–99; operative 11–25–99 (Register 99, No. 44).

§ 2851. Surety Bond Format.

A corporate survey bond provided to the Department by prepaid rental listing service pursuant to Section 10167.7 of the Code shall be in substantially the following form:

PREPAID RENTAL LISTING SERVICE BOND

Bond No._____

Premium $_____

Know all men by these presents:

That we, _____ as _____ PRINCIPAL and _____ a corporation organized under the laws of the State of _____ _____ and authorized to transact the business of surety in the State of California as SURETY are held and firmly bound unto the State of California (OBLIGEE) in the penal sum of _____ dollars ($_____) for which payment, well and truly to be made, we bind ourselves, our heirs, administrators, successors and assigns, jointly and severally liable and liable on the obligations of the bond and the statute providing for the bond.

PRINCIPAL has applied to the Department of Real Estate of the State of California for a license to act as a Prepaid Rental Listing Service, or for the renewal of said license and is required by Section 10167.7 of the Business and Professions Code to have on file with the Department of Real Estate, a bond in the amount of $10,000 for each licensed location. This bond is executed and tendered in accordance with Section 10167.7.

The condition of this obligation is that if PRINCIPAL satisfies any and all final judgments entered against PRINCIPAL as the result of any action undertaken pursuant to subdivision (f) of Section 10167.10, then this obligation shall be null and void. Otherwise it shall remain in full force and effect.

For value received, SURETY does hereby waive any right granted to SURETY by Section 2845 if the California Civil Code to require that OBLIGEE proceed independently against PRINCIPAL to enforce this obligation or that the underlying judgment creditor of PRINCIPAL pursue any other remedies for the collection of said judgment.

This bond is continuous in form and shall remain in full force and effect and shall run concurrently with the term of the Rental Listing Service License issued to PRINCIPAL and for the term of any renewal thereof unless earlier terminated or cancelled by SURETY as provided by law.

The SURETY, its successors and assigns, are jointly and severally liable on the obligations of the bond, chapter 2 (commencing with section

[The next page is 817.]

995.010), Title 14, part 2, Code of Civil Procedure and Article 2.3, Chapter 3, Part 1, Division 4, Business and Professions Code.

The PRINCIPAL and SURETY may be served with notices, papers and other documents under chapter 2 (commencing with section 995.010), Title 14, part 2, Code of Civil Procedure at the addresses given above.

I certify (declare) under penalty of perjury under the laws of the State of California that I have executed this foregoing bond.

PRINCIPAL and SURETY have executed this agreement this _____ day of _____, 20___.

_____	_____
(Principal)	(Surety)
Address:	Address:
_____	_____
_____	_____
_____	_____
By: _____	By: _____
(Signature)	(Signature)

NOTE: Authority cited: Section 10080, Business and Professions Code; and Section 11110, Government Code. Reference: Section 10167.7, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
2. Amendment filed 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
3. Amendment filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
4. Amendment of section and NOTE filed 9–19–2002; operative 10–19–2002 (Register 2002, No. 38).
5. Amendment filed 3–17–2005; operative 4–16–2005 (Register 2005, No. 11).

§ 2851.1. Cash Deposit Security Format.

The following shall constitute an acceptable format for the creation and assignment of a cash deposit to the Commissioner pursuant to Section 10167.7 of the Code:

PREPAID RENTAL LISTING SERVICE
CASH DEPOSIT SECURITY

_____ (ASSIGNOR), a prepaid rental listing service licensee whose principal licensed location is at: _____ _____ hereby assigns to the Real Estate Commissioner of the State of California (ASSIGNEE) all of ASSIGNOR'S right, title and interest in a cash deposit /certificate of deposit in the amount of _____ ($_____) identified as follows:

Name and/or Number _____
Depository/Issuer _____
Name
Address _____
City and State _____

ASSIGNOR has applied to the Department of Real Estate of the State of California for a license to act as a prepaid listing service, or for the renewal of said license, and is required by Section 10167.7 of the Business and Professions Code to provide a cash deposit in the amount of $10,000 for each licensed location. This assignment is made in accordance with and pursuant to Section 1067.7.

This assignment includes any or all rights arising out of insurance of the principal amount of the account by the Federal Deposit Insurance Corporation or other insurer, but ASSIGNOR retains for himself all rights to interest earned on the principal and all rights arising out of insurance of the unpaid interest earned on the principal amount.

ASSIGNOR hereby gives to ASSIGNEE or his duly appointed representative the authority to withdraw funds from the account at any time without notice to ASSIGNOR for the purpose of paying unsatisfied judgements in accordance with Section 10167.7. This authority of ASSIGNEE shall include the power to convert a Certificate of Deposit or similar evidence of a deposit to cash as necessary to make payments for the benefit of unsatisfied judgement creditors notwithstanding the fact that such conversion may result in an interest penalty.

The Certificate of Deposit or other certificate evidencing the above identified account shall be retained in the custody of ASSIGNEE while this assignment remains in effect. This assignment shall remain effective until ASSIGNEE shall determine that there is not longer any potential liability of ASSIGNOR under Section 10167.10 of the Code.

DATED_____, 20___

_____
Signature of Assignor*

*If an account or certificate is in the name of a corporation, the assignment must be signed by an officer of the corporation.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10167.7, Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
2. Amendment of section and NOTE filed 9–19–2002; operative 10–19–2002 (Register 2002, No. 38).

§ 2851.2. Restoration of Surety Bond or Cash Deposit.

NOTE: Authority cited: Section 10080, Business and Professions Code, Reference: Section 10167.7 (Ch. 1051, Statutes of 1980, SB 1564), Business and Professions Code.

HISTORY

1. New section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
2. Repealer filed 10–26–99; operative 11–25–99 (Register 99, No. 44).

§ 2852. Change of Location for Office Address.

(a) If a prepaid rental listing service (PRLS) licensee or a real estate broker operating a prepaid rental listing service under his broker license proposes to move either the principal location or main office to a different address, he shall, prior to effecting the move, give notice of the address and telephone number of the new principal location or main office in a manner reasonably calculated to reach all of the prospective tenants with whom the PRLS licensee or broker has contracts that have not expired.

(b) If a PRLS licensee or a real estate broker operating a prepaid rental listing service under his broker license proposes to move either a branch location or branch office to a different address, he shall, prior to effecting the move, give notice of the address and telephone number of the new branch location or branch office in a manner reasonably calculated to reach all of the prospective tenants previously supplied with listings of rental properties by the branch location or branch office under contracts that have not expired.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Article 23 (Ch. 1051, Statutes of 1980, SB 1564), Business and Professions Code.

HISTORY

1. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
2. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Repealer and new section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2852.1. Different Names for Branch Locations.

If a licensee conducts a prepaid rental listing service business under different fictitious business names at separate locations or branch office within the boundaries of the same city or within ten miles of the boundary of that city, the name or fictitious business name under which each office or location is operated and the corresponding address of each office shall be set forth in the contract referred to in Section 10167.9 of the Code.

NOTE: Authority cited: Section 10081, Business and Professions Code. Reference: Sections 10167.9, 10167.10 and 10167.11, Business and Professions Code.

HISTORY

1. New section filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2). For prior history, see Register 80, No. 49.

§ 2852.2. Change of Business Office Location.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Article 2.3 (Ch. 1051, Statutes of 1980, SB 1564), Business and Professions Code.

HISTORY
1. New section filed 1–7–75; designated effective 3–1–75 (Register 75, No. 2).
2. Repealer filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2852.3. Handling and Disposition of Advance Rental Fee.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Article 2.3 (Ch. 1051, Statutes of 1980, SB 1564), Business and Professions Code.

HISTORY
1. New section filed 1–7–75; designated effective 3–1–75 (Register 75, No. 2).
2. Amendment filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
3. Repealer filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

§ 2853. Notice of Remedies for Failure to Refund.

The clause required under subdivision (a)(8) of Section 10167.9 of the Code in a prepaid rental listing service contract shall appear in bold face type immediately below the RIGHT TO REFUND notice specified in Section 10167.10 of the Code and shall read as follows:

"You may bring a small claims court action against the licensee for his/her refusal to make a refund on your demand of all or part of the fee paid by you under this contract. If the court finds that the licensee has acted in bad faith in refusing to make the refund, the court has the authority to award you up to one thousand dollars ($1,000) in addition to damages actually sustained by you."

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10167.9 and 10167.10, Business and Professions Code.

HISTORY
1. New section filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2). For prior history, see Register 80, No. 49 and 80. No. 3.
2. Amendment of second paragraph and amendment of NOTE filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2854. List of Addresses.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10143, Business and Professions Code.

HISTORY
1. Repealer filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).

§ 2855. Registry of Advertisements.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10143, Business and Professions Code.

HISTORY
1. Repealer filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).

§ 2856. Authorization Required.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Article 23 (Ch. 1051, Statutes of 1980, SB 1564), Business and Professions Code.

HISTORY
1. Amendment filed 11–19–69; designated effective 1–2–70 (Register 80, No. 3).
2. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Repealer and new section filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).

Article 17.5. Mobile Home Sales

§ 2860. Transfer of Registration.

(a) A real estate broker acting pursuant to Section 10131.6 of the Code shall, not later than the end of the tenth calendar day after the sale of a mobilehome, that is subject to registration, give written notice of the transfer to the headquarters office of the Department of Housing and Community Development as prescribed by that Department.

(b) In a transaction in which the certificate of ownership of a mobilehome that is subject to registration is not demanded in writing by the purchaser, a real estate broker acting pursuant to Section 10131.6 of the Code shall submit the following to the Department of Housing and Community Development on behalf of the purchaser within 10 days after the sale:

(1) All fees and penalties for transfer of registration of the mobilehome.

(2) The ownership certificate and last–issued registration card for the mobilehome and any other supporting documents required by the Department of Housing and Community Development.

(3) The use tax payable in the transaction.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10131.6, Business and Professions Code; and Section 18100.5, Health and Safety Code.

HISTORY
1. New section filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36). For prior history, see Register 96, No. 46.

§ 2861. Notice of Transfer of Registration.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10131.6, Business and Professions Code, and Section 18100.5, Health and Safety Code.

HISTORY
1. Amendment filed 5–18–81; effective thirtieth day thereafter (Register 81, No. 21).
2. Amendment filed 1–11–84; effective thirtieth day thereafter (Register 84, No. 2).
3. Repealer of section and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2862. Submittal of Documents and Fees on Transfer.

NOTE: Authority cited: Section 10131.6, Business and Professions Code. Reference: Section 18075 et seq., Health and Safety Code.

HISTORY
1. Amendment filed 1–16–76; effective thirtieth day thereafter (Register 76, No. 3).
2. Amendment filed 5–18–81; effective thirtieth day thereafter (Register 81, No. 21).
3. Editorial correction filed 7–16–81 (Register 81, No. 29).
4. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2863. Use of Fictitious Name.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10177.2, Business and Professions Code.

HISTORY
1. Repealer of section and new NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 18. Contracts, Writings and Other Documents

§ 2900. Blank Spaces in Instruments.

NOTE: Authority cited for Article 18: Section 10080, and 10170.4 and 10176.2, Business and Professions Code.

HISTORY
1. New Article 18 (2900 through 2902) filed 12–11–57 effective thirtieth day thereafter (Register 57, No. 22).
2. Amendment filed 11–30–77; effective thirtieth day thereafter (Register 77, No. 49).
3. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2901. Additions or Modifications.

HISTORY
1. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2902. Furnishing Copies.

HISTORY
1. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2903. Structural Defects, Disclosure.

HISTORY
1. New section filed 8–23–61; effective thirtieth day thereafter (Register 61, No. 17).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2904. Disclosure of Compensation for Obtaining Financing.

It shall constitute misrepresentation under Section 10176(a) of the Code for a real estate licensee who acts as an agent for either party in a transaction for the sale, lease or exchange of real property, a business opportunity or a mobilehome as described in Section 10131.6 of the Code, and who receives compensation, or who anticipates receiving compensation, from a lender in connection with the securing of financing for the transaction, to fail to disclose to both parties, prior to the closing of the transaction, the form, amount and source of compensation received or expected.

NOTE: Authority cited: Section 10080, 10170.4, 10226, 10149.2 11001, and 11011.8, Business and Professions Code and Sections 21082, Public Resources Code.

HISTORY

1. New section filed 12–2–74; effective thirtieth day thereafter (Register 74, No. 49). For history of former section, see Register 63, No. 14.
2. Amendment filed 2–10–77; effective thirtieth day thereafter (Register 77, No. 7).
3. Amendment filed 11–30–77; effective thirtieth day thereafter (Register 77, No. 49).

§ 2905. Pest Control Documentation.

In a real estate transaction subject to the provisions of Section 1099 of the Civil Code, the real estate broker acting as agent for the seller in the transaction shall effect delivery of the inspection report, certification and the notice of work completed, if any, to the transferee in accordance with said section.

If more than one real estate broker licensee is acting as an agent of the transferor in the transaction, the broker who has obtained the offer made by the transferee shall effect delivery of the required documents to the transferee unless the transferor has given written directions to another real estate broker licensee acting as agent of the transferor in the transaction to effect delivery.

If the agent cannot obtain the required documents to deliver to the transferee and does not have written assurance from the transferee that all of said documents have been received, the agent shall advise the transferee in writing of the transferee's rights under Section 1099.

The broker shall maintain a record of the action taken to effect compliance with this regulation in accordance with Section 10148 of the Business and Professions Code.

NOTE: Authority cited: Sections 10080 and 10131.6, Business and Professions Code. Reference: Section 10148, Business and Professions Code.

HISTORY

1. New section filed 6–13–75 as an emergency; designated effective 71–15–75 (Register 75, No. 24).
2. Certificate of Compliance filed 8–28–75 (Register 75, No. 35).
3. Amendment filed 1–6–76; effective thirtieth day thereafter (Register 76, No. 3).
4. Amendment of section and NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 18.5. Substantial Relationship and Rehabilitation Criteria

§ 2910. Criteria of Substantial Relationship.

(a) When considering whether a license should be denied, suspended or revoked on the basis of the conviction of a crime, or on the basis of an act described in Section 480(a)(2) or 480(a)(3) of the Code, the crime or act shall be deemed to be substantially related to the qualifications, functions or duties of a licensee of the Department within the meaning of Sections 480 and 490 of the Code if it involves:

(1) The fraudulent taking, obtaining, appropriating or retaining of funds or property belonging to another person.

(2) Counterfeiting, forging or altering of an instrument or the uttering of a false statement.

(3) Willfully attempting to derive a personal financial benefit through the nonpayment or underpayment of taxes, assessments or levies duly imposed upon the licensee or applicant by federal, state, or local government.

(4) The employment of bribery, fraud, deceit, falsehood or misrepresentation to achieve an end.

(5) Sexually related conduct affecting a person who is an observer or non–consenting participant in the conduct or convictions which require registration pursuant to the provisions of Section 290 of the Penal Code.

(6) Willfully violating or failing to comply with a provision of Division 4 of the Business and Professions Code of the State of California.

(7) Willfully violating or failing to comply with a statutory requirement that a license, permit or other entitlement be obtained from a duly constituted public authority before engaging in a business or course of conduct.

(8) Doing of any unlawful act with the intent of conferring a financial or economic benefit upon the perpetrator or with the intent or threat of doing substantial injury to the person or property of another.

(9) Contempt of court or willful failure to comply with a court order.

(10) Conduct which demonstrates a pattern of repeated and willful disregard of law.

(11) Two or more convictions involving the consumption or use of alcohol or drugs when at least one of the convictions involve driving and the use or consumption of alcohol or drugs.

(b) The conviction of a crime constituting an attempt, solicitation or conspiracy to commit any of the above enumerated acts or omissions is also deemed to be substantially related to the qualifications, functions or duties of a licensee of the department.

(c) If the crime or act is substantially related to the qualifications, functions or duties of a licensee of the department, the context in which the crime or acts were committed shall go only to the question of the weight to be accorded to the crime or acts in considering the action to be taken with respect to the applicant or licensee.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 480, 481 and 490, Business and Professions Code; and *In re Gossage* (2000) 23 Cal 4th 1080.

HISTORY

1. New Article 18.5 (Sections 2910–2912) filed 4–24–78, effective thirtieth day thereafter (Register 78, No. 17).
2. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of subsection (a)(5) and new subsections (a)(9) and (a)(10) filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).
4. Amendment of subsection (a)(2), new subsection (a)(11) and amendment of NOTE filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2911. Criteria of Rehabilitation (Denial).

The following criteria have been developed by the department pursuant to Section 482(a) of the Business and Professions Code for the purpose of evaluating the rehabilitation of an applicant for issuance or for reinstatement of a license in considering whether or not to deny the issuance or reinstatement on account of a crime or act committed by the applicant:

(a) The passage of not less than two years since the most recent criminal conviction or act of the applicant that is a basis to deny the departmental action sought. (A longer period will be required if there is a history of acts or conduct substantially related to the qualifications, functions or duties of a licensee of the department.)

(b) Restitution to any person who has suffered monetary losses through "substantially related" acts or omissions of the applicant.

(c) Expungement of criminal convictions resulting from immoral or antisocial acts.

(d) Expungement or discontinuance of a requirement of registration pursuant to the provisions of Section 290 of the Penal Code.

(e) Successful completion or early discharge from probation or parole.

(f) Abstinence from the use of controlled substances or alcohol for not less than two years if the conduct which is the basis to deny the departmental action sought is attributable in part to the use of controlled substances or alcohol.

(g) Payment of the fine or other monetary penalty imposed in connection with a criminal conviction or quasi–criminal judgment.

(h) Stability of family life and fulfillment of parental and familial responsibilities subsequent to the conviction or conduct that is the basis for denial of the agency action sought.

(i) Completion of, or sustained enrollment in, formal education or vocational training courses for economic self–improvement.

(j) Discharge of, or bona fide efforts toward discharging, adjudicated debts or monetary obligations to others.

(k) Correction of business practices resulting in injury to others or with the potential to cause such injury.

(*l*) Significant or conscientious involvement in community, church or privately–sponsored programs designed to provide social benefits or to ameliorate social problems.

(m) New and different social and business relationships from those which existed at the time of the conduct that is the basis for denial of the departmental action sought.

(n) Change in attitude from that which existed at the time of the conduct in question as evidenced by any or all of the following:

(1) Testimony of applicant.

(2) Evidence from family members, friends or other persons familiar with applicant's previous conduct and with his subsequent attitudes and behavioral patterns.

(3) Evidence from probation or parole officers or law enforcement officials competent to testify as to applicant's social adjustments.

(4) Evidence from psychiatrists or other persons competent to testify with regard to neuropsychiatric or emotional disturbances.

(5) Absence of subsequent felony or misdemeanor convictions that are reflective of an inability to conform to societal rules when considered in light of the conduct in question.

NOTE: Authority cited: Sections 482 and 10080, Business and Professions Code. Reference: Section 482, Business and Professions Code; and *In re Gossage* (2000) 23 Cal 4th 1080.

HISTORY

1. New subsection (d), subsection relettering and new NOTE filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).
2. New subsection (n)(5) and amendment of NOTE filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2912. Criteria of Rehabilitation (Revocation or Suspension).

The following criteria have been developed by the department pursuant to Section 482(b) of the Business and Professions Code for the purpose of evaluating the rehabilitation of a licensee against whom an administrative disciplinary proceeding for revocation or suspension of the license has been initiated on account of a crime committed by the licensee.

(a) The passage of not less than two years from the most recent criminal conviction that is "substantially related" to the qualifications, functions or duties of a licensee of the department. (A longer period will be required if there is a history of criminal convictions or acts substantially related to the qualifications, functions or duties of a licensee of the department.)

(b) Restitution to any person who has suffered monetary losses through "substantially related" acts or omissions of the licensee.

(c) Expungement of the conviction or convictions which culminated in the administrative proceeding to take disciplinary action.

(d) Expungement or discontinuance of a requirement of registration pursuant to the provisions of Section 290 of the Penal Code.

(e) Successful completion or early discharge from probation or parole.

(f) Abstinence from the use of controlled substances or alcohol for not less than two years if the criminal conviction was attributable in part to the use of a controlled substance or alcohol.

(g) Payment of any fine imposed in connection with the criminal conviction that is the basis for revocation or suspension of the license.

(h) Correction of business practices responsible in some degree for the crime or crimes of which the licensee was convicted.

(i) New and different social and business relationships from those which existed at the time of the commission of the acts that led to the criminal conviction or convictions in question.

(j) Stability of family life and fulfillment of parental and familial responsibilities subsequent to the criminal conviction.

(k) Completion of, or sustained enrollment in, formal educational or vocational training courses for economic self–improvement.

(*l*) Significant and conscientious involvement in community, church or privately–sponsored programs designed to provide social benefits or to ameliorate social problems.

(m) Change in attitude from that which existed at the time of the commission of the criminal acts in question as evidenced by any or all of the following:

(1) Testimony of applicant.

(2) Evidence from family members, friends or other persons familiar with the licensee's previous conduct and with subsequent attitudes and behavioral patterns.

(3) Evidence from probation or parole officers or law enforcement officials competent to testify as to applicant's social adjustments.

(4) Evidence from psychiatrists, clinical psychologists, sociologists or other persons competent to testify with regard to neuropsychiatric or emotional disturbances

(5) Absence of subsequent felony or misdemeanor convictions that are reflective of an inability to conform to societal rules when considered in light of the conduct in question.

NOTE: Authority cited: Sections 482 and 10080, Business and Professions Code. Reference: Section 482, Business and Professions Code and *In re Gossage* (2000) 23 Cal 4th 1080.

HISTORY

1. Amendment of subsection (l)(4) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
2. New subsection (d) and subsection relettering filed 6–20–2002; operative 7–20–2002 (Register 2002, No. 25).
3. New subsection (m)(5) and amendment of NOTE filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

Article 18.6. Monetary Penalty in Lieu of Suspension

§ 2920. Amount of Penalty.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10175.2, Business and Professions Code.

HISTORY

1. New section filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 2921. Procedures.

(a) Licensees may petition in writing for a monetary penalty at any time after filing of an accusation and before the effective date of a decision.

(b) No specific form of petition is required. It may contain argument to support a grant of the petition or any other relevant material the petitioner desires to present to the Commissioner.

(c) Upon receipt of a timely petition, the Commissioner shall grant a stay of the effective date of the decision, if any, for a period of up to 30 days for the purpose of determining whether the public interest and welfare will be adequately served if the petition is granted.

(d) Any order granting a petition for a monetary penalty in lieu of a license suspension order shall be published in the "Real Estate Bulletin."

NOTE: Authority cited: Sections 10080 and 10083, Business and Professions Code. Reference: Section 10175.2, Business and Professions Code.

HISTORY

1. New section filed 11–16–87; operative 12–16–87 (Register 87, No. 47).

§ 2922. Payment.

Payment of a monetary penalty shall be by means of a certified or cashier's check made payable to the Department of Real Estate.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10175.2, Business and Professions Code.

HISTORY
1. New section filed 11-16-87; operative 12-16-87 (Register 87, No. 47).

Article 18.7. Standard Proposed Decision Language

§ 2930. Standard Proposed Decision Language.

The following language, terms and conditions will be used, as appropriate, in Proposed Decisions and Decisions of the commissioner in administrative adjudications conducted pursuant to Sections 11500, et seq. of the Government Code:

1. Revocation:

All licenses and licensing rights of Respondent _____ under the Real Estate Law are revoked.

2. Revocation With Right to Restricted License—Broker:

All licenses and licensing rights of Respondent _____ under the Real Estate Law are revoked; provided, however, a restricted real estate broker license shall be issued to Respondent pursuant to Section 10156.5 of the Business and Professions Code if Respondent makes application therefor and pays to the Department of Real Estate the appropriate fee for the restricted license within 90 days from the effective date of this Decision. The restricted license issued to Respondent shall be subject to all of the provisions of Section 10156.7 of the Business and Professions Code and to the following limitations, conditions and restrictions imposed under authority of Section 10156.6 of that Code:

1. The restricted license issued to Respondent may be suspended prior to hearing by Order of the Real Estate Commissioner in the event of Respondent's conviction or plea of nolo contendere to a crime which is substantially related to Respondent's fitness or capacity as a real estate licensee.

2. The restricted license issued to Respondent may be suspended prior to hearing by Order of the Real Estate Commissioner on evidence satisfactory to the Commissioner that Respondent has violated provisions of the California Real Estate Law, the Subdivided Lands Law, Regulations of the Real Estate Commissioner or conditions attaching to the restricted license.

3. Respondent shall not be eligible to apply for the issuance of an unrestricted real estate license nor for the removal of any of the conditions, limitations or restrictions of a restricted license until two years have elapsed from the effective date of this Decision.

4. Respondent shall, within nine months from the effective date of this Decision, present evidence satisfactory to the Real Estate Commissioner that Respondent has, since the most recent issuance of an original or renewal real estate license, taken and successfully completed the continuing education requirements of Article 2.5 of Chapter 3 of the Real Estate Law for renewal of a real estate license. If Respondent fails to satisfy this condition, the Commissioner may order the suspension of the restricted license until the Respondent presents such evidence. The Commissioner shall afford Respondent the opportunity for a hearing pursuant to the Administrative Procedure Act to present such evidence.

3. Revocation With Right to Restricted License—Salesperson:

All licenses and licensing rights of Respondent _____ under the Real Estate Law are revoked; provided, however, a restricted real estate salesperson license shall be issued to Respondent pursuant to Section 10156.5 of the Business and Professions Code if Respondent makes application therefor and pays to the Department of Real Estate the appropriate fee for the restricted license within 90 days from the effective date of this Decision. The restricted license issued to Respondent shall be subject to all of the provisions of Section 10156.7 of the Business and Professions Code and to the following limitations, conditions and restrictions imposed under authority of Section 10156.6 of that Code:

1. The restricted license issued to Respondent may be suspended prior to hearing by Order of the Real Estate Commissioner in the event of Respondent's conviction or plea of nolo contendere to a crime which is substantially related to Respondent's fitness or capacity as a real estate licensee.

2. The restricted license issued to Respondent may be suspended prior to hearing by Order of the Real Estate Commissioner on evidence satisfactory to the Commissioner that Respondent has violated provisions of the California Real Estate Law, the Subdivided Lands Law, Regulations of the Real Estate Commissioner or conditions attaching to the restricted license.

3. Respondent shall not be eligible to apply for the issuance of an unrestricted real estate license nor for the removal of any of the conditions, limitations or restrictions of a restricted license until two years have elapsed from the effective date of this Decision.

4. Respondent shall submit with any application for license under an employing broker, or any application for transfer to a new employing broker, a statement signed by the prospective employing real estate broker on a form approved by the Department of Real Estate which shall certify:

(a) That the employing broker has read the Decision of the Commissioner which granted the right to a restricted license; and

(b) That the employing broker will exercise close supervision over the performance by the restricted licensee relating to activities for which a real estate license is required.

5. Respondent shall, within nine months from the effective date of this Decision, present evidence satisfactory to the Real Estate Commissioner that Respondent has, since the most recent issuance of an original or renewal real estate license, taken and successfully completed the continuing education requirements of Article 2.5 of Chapter 3 of the Real Estate Law for renewal of a real estate license. If Respondent fails to satisfy this condition, the Commissioner may order the suspension of the restricted license until the Respondent presents such evidence. The Commissioner shall afford Respondent the opportunity for a hearing pursuant to the Administrative Procedure Act to present such evidence.

4. Suspension Added to Revocation With Right to a Restricted License:

Any restricted real estate license issued to Respondent pursuant to this Decision shall be suspended for ____ days from the date of issuance of said restricted license.

5. Professional Responsibility Condition:

Respondent shall, within six months from the effective date of this Decision, take and pass the Professional Responsibility Examination administered by the Department including the payment of the appropriate examination fee. If Respondent fails to satisfy this condition, the Commissioner may order suspension of Respondent's license until Respondent passes the examination.

6. Conditional License Condition—Salesperson Only—(Accusation):

Respondent's original real estate salesperson license was issued subject to the provisions of Section 10153.4 of the Business and Professions Code, and the restricted real estate salesperson license issued to Respondent shall be similarly limited, to wit: Respondent shall, within eighteen (18) months of the issuance of Respondent's original real estate salesperson license under the provisions of Section 10153.4 of the Business and Professions Code, submit evidence satisfactory to the Commissioner of successful completion, at an accredited institution, of a course in real estate practices and one of the courses listed in Section 10153.2, other than real estate principles, advanced legal aspects of real estate, advanced real estate finance or advanced real estate appraisal. If Respondent fails to present satisfactory evidence of successful completion of said courses, the restricted license shall be automatically suspended effective eighteen (18) months after issuance of Respondent's original real estate salesperson license. Said suspension shall not be lifted until Respondent has submitted the required evidence of course completion and the Commissioner has given written notice to the Respondent of lifting of the suspension.

7. Restitution Condition:

Respondent shall, prior to the issuance of the restricted license and as a condition of the issuance of said restricted license, submit proof satis-

factory to the Commissioner of payment of restitution in the amount of _____ to _____.

8. Reporting Condition (Broker Only):

Respondent shall report in writing to the Department of Real Estate as the Real Estate Commissioner shall direct by his Decision herein or by separate written order issued while the restricted license is in effect such information concerning Respondent's activities for which a real estate license is required as the Commissioner shall deem to be appropriate to protect the public interest.

Such reports may include, but shall not be limited to, periodic independent accountings of trust funds in the custody and control of Respondent and periodic summaries of salient information concerning each real estate transaction in which the Respondent engaged during the period covered by the report.

9. Suspension (Broker and Salesperson):

All licenses and licensing rights of Respondent _____ under the Real Estate Law are suspended for a period of _____ (____) days from the effective date of this Decision.

10. Suspension With All or a Portion Stayed (Broker and Salesperson):

All licenses and licensing rights of Respondent _____ under the Real Estate Law are suspended for a period of _____(____) days from the effective date of this Decision; provided, however, that _____(____) days of said suspension shall be stayed for one (1) year upon the following terms and conditions:

1. Respondent shall obey all laws, rules and regulations governing the rights, duties and responsibilities of a real estate licensee in the State of California; and

2. That no final subsequent determination be made, after hearing or upon stipulation, that cause for disciplinary action occurred within one (1) year of the effective date of this Decision. Should such a determination be made, the Commissioner may, in his discretion, vacate and set aside the stay order and reimpose all or a portion of the stayed suspension. Should no such determination be made, the stay imposed herein shall become permanent.

11. Suspension With Monetary Penalty in Lieu of Suspension Pursuant to Business and Professions Code Section 10175.2 (Broker and Salesperson):

All licenses and licensing rights of Respondent _____ under the Real Estate Law are suspended for a period of _____(____) days from the effective date of this Decision; provided, however, that if Respondent petitions, said suspension (or a portion thereof) shall be stayed upon condition that:

1. Respondent pays a monetary penalty pursuant to Section 10175.2 of the Business and Professions Code at the rate of $_____ for each day of the suspension for a total monetary penalty of $_____.

2. Said payment shall be in the form of a cashier's check or certified check made payable to the Recovery Account of the Real Estate Fund. Said check must be received by the Department prior to the effective date of the Decision in this matter.

3. No further cause for disciplinary action against the real estate license of Respondent occurs within one year from the effective date of the Decision in this matter.

4. If Respondent fails to pay the monetary penalty in accordance with the terms and conditions of the Decision, the Commissioner may, without a hearing, order the immediate execution of all or any part of the stayed suspension in which event the Respondent shall not be entitled to any repayment nor credit, prorated or otherwise, for money paid to the Department under the terms of this Decision.

5. If Respondent pays the monetary penalty and if no further cause for disciplinary action against the real estate license of Respondent occurs within one year from the effective date of the Decision, the stay hereby granted shall become permanent.

12. Denial of Broker License Application With Right to a Restricted Broker License. (Note: The continuing education condition should not be used in application cases):

Respondent's application for a real estate broker license is denied; provided, however, a restricted real estate broker license shall be issued to Respondent pursuant to Section 10156.5 of the Business and Professions Code. The restricted license issued to the Respondent shall be subject to all of the provisions of Section 10156.7 of the Business and Professions Code and to the following limitations, conditions and restrictions imposed under authority of Section 10156.6 of said Code:

1. The license shall not confer any property right in the privileges to be exercised, and the Real Estate Commissioner may by appropriate order suspend the right to exercise any privileges granted under this restricted license in the event of:

(a) The conviction of Respondent (including a plea of nolo contendere) of a crime which is substantially related to Respondent's fitness or capacity as a real estate licensee; or

(b) The receipt of evidence that Respondent has violated provisions of the California Real Estate Law, the Subdivided Lands Law, Regulations of the Real Estate Commissioner or conditions attaching to this restricted license.

2. Respondent shall not be eligible to apply for the issuance of an unrestricted real estate license nor the removal of any of the conditions, limitations or restrictions attaching to the restricted license until two years have elapsed from the date of issuance of the restricted license to Respondent.

13. Denial of Salesperson License Application With Right to a Restricted Salesperson License (Unconditional). (Note: The continuing education condition should not be used in application cases):

Respondent's application for a real estate salesperson license is denied; provided, however, a restricted real estate salesperson license shall be issued to Respondent pursuant to Section 10156.5 of the Business and Professions Code. The restricted license issued to the Respondent shall be subject to all of the provisions of Section 10156.7 of the Business and Professions Code and to the following limitations, conditions and restrictions imposed under authority of Section 10156.6 of said Code:

1. The license shall not confer any property right in the privileges to be exercised, and the Real Estate Commissioner may by appropriate order suspend the right to exercise any privileges granted under this restricted license in the event of:

(a) The conviction of Respondent (including a plea of nolo contendere) of a crime which is substantially related to Respondent's fitness or capacity as a real estate licensee; or

(b) The receipt of evidence that Respondent has violated provisions of the California Real Estate Law, the Subdivided Lands Law, Regulations of the Real Estate Commissioner or conditions attaching to this restricted license.

2. Respondent shall not be eligible to apply for the issuance of an unrestricted real estate license nor the removal of any of the conditions, limitations or restrictions attaching to the restricted license until two years have elapsed from the date of issuance of the restricted license to Respondent.

3. With the application for license, or with the application for transfer to a new employing broker, Respondent shall submit a statement signed by the prospective employing real estate broker on a form RE 552 (Rev. 4/88) approved by the Department of Real Estate which shall certify as follows:

(a) That the employing broker has read the Decision which is the basis for the issuance of the restricted license; and

(b) That the employing broker will carefully review all transaction documents prepared by the restricted licensee and otherwise exercise close supervision over the licensee's performance of acts for which a license is required.

14. Denial of Application for Conditional Salesperson Application or Revocation of Conditional Salesperson License. (Note: A license is "conditional" when the respondent has not completed the two additional courses required by Section 10153.4):

Denial: Restricted License:

1. Respondent's restricted real estate salesperson license is issued subject to the requirements of Section 10153.4 of the Business and Professions Code, to wit: Respondent shall, within eighteen (18) months of the issuance of the restricted license, submit evidence satisfactory to the Commissioner of successful completion, at an accredited institution, of a course in real estate practices and one of the courses listed in Section 10153.2, other than real estate principles, advanced legal aspects of real estate, advanced real estate finance or advanced real estate appraisal. If Respondent fails to timely present to the Department satisfactory evidence of successful completion of the two required courses, the restricted license shall be automatically suspended effective eighteen (18) months after the date of its issuance. Said suspension shall not be lifted unless, prior to the expiration of the restricted license, Respondent has submitted the required evidence of course completion and the Commissioner has given written notice to Respondent of lifting of the suspension.

2. Pursuant to Section 10154, if Respondent has not satisfied the requirements for an unqualified license under Section 10153.4, Respondent shall not be entitled to renew the restricted license, and shall not be entitled to the issuance of another license which is subject to Section 10153.4 until four years after the date of the issuance of the preceding restricted license.

Revocation: Restricted License. (Applicable if less than eighteen (18) months have passed since the issuance of the conditional license being revoked):

1. Respondent's restricted real estate salesperson license is issued subject to the requirements of Section 10153.4 of the Business and Professions Code, to wit: Respondent shall, within eighteen (18) months of the issuance of the license revoked herein, submit evidence satisfactory to the Commissioner of successful completion, at an accredited institution, of a course in real estate practices and one of the courses listed in Section 10153.2, other than real estate principles, advanced legal aspects of real estate, advanced real estate finance or advanced real estate appraisal. If Respondent fails to present to the Department satisfactory evidence of successful completion of the two required courses, the restricted license shall be automatically suspended effective eighteen (18) months after the date of issuance of the license revoked herein. Said suspension shall not be lifted unless prior to the expiration of the restricted license Respondent has submitted the required evidence of course completion and the Commissioner has given written notice to Respondent of lifting of the suspension.

2. Pursuant to Section 10154, if Respondent has not satisfied the requirements for an unqualified license under Section 10153.4, Respondent shall not be entitled to renew the restricted license, and shall not be entitled to the issuance of another license which is subject to Section 10153.4 until four years after the date of the issuance of the preceding restricted license.

Revocation: Restricted License. (More than 18 months have passed since the issuance of the conditional license being revoked):

1. Prior to the delivery or mailing of Respondent's restricted license, Respondent shall submit evidence satisfactory to the Commissioner of successful completion, at an accredited institution, of a course in real estate practices and one of the courses listed in Section 10153.2, other than real estate principles, advanced legal aspects of real estate, advanced real estate finance or advanced real estate appraisal. If Respondent fails to present to the Department satisfactory evidence of successful completion of the two required courses, the restricted license shall be automatically suspended. Said suspension shall not be lifted unless, prior to the expiration of the restricted license, Respondent has submitted the required evidence of course completion and the Commissioner has given written notice to Respondent of lifting of the suspension.

2. If Respondent has not satisfied the requirements for an unqualified license within four years from the date of issuance of the restricted license revoked herein, Respondent shall not be entitled to renew the restricted license, and shall not be entitled to the issuance of another license which is subject to Section 10153.4 until four years after the date of the issuance of the preceding restricted license.

15. Trust Fund Violations: Standard Terms and Conditions for a Restricted License:

Pursuant to Section 10148 of the Business and Professions Code, Respondent shall pay the Commissioner's reasonable cost for: a) the audit which led to this disciplinary action and, b) a subsequent audit to determine if Respondent has corrected the trust fund violation(s) found in paragraphs _____ of the Determination of Issues. In calculating the amount of the Commissioner's reasonable cost, the Commissioner may use the estimated average hourly salary for all persons performing audits of real estate brokers, and shall include an allocation for travel time to and from the auditor's place of work. Respondent shall pay such cost within 60 days of receiving an invoice from the Commissioner detailing the activities preformed during the audit and the amount of time spent performing those activities. The Commissioner may suspend the restricted license issued to respondent pending a hearing held in accordance with Section 11500, et seq., of the Government Code, if payment is not timely made as provided for herein, or as provided for in a subsequent agreement between the Respondent and the Commissioner. The suspension shall remain in effect until payment is made in full or until Respondent enters into an agreement satisfactory to the Commissioner to provide for payment, or until a decision providing otherwise is adopted following a hearing held pursuant to this condition.

16. Trust Fund Violations: Standard Terms and Conditions for a Suspended License:

All licenses and licensing rights of Respondent are suspended for two years from the effective date of this Decision; provided, however, that the suspension shall be stayed upon the following terms and conditions:

1. Respondent's license and license rights shall be actually suspended for a period of ____ days. Respondent may, pursuant to Section 10175.2, petition the Commissioner to pay a monetary penalty and thereby further stay imposition of the term of the actual suspension. (Note: The last sentence is optional.)

2. Respondent shall obey all laws, rules and regulations governing the rights, duties and responsibilities of a real estate licensee in the State of California.

3. The Commissioner may, if a final subsequent determination is made, after hearing or upon stipulation, that cause for disciplinary action occurred during the term of the suspension provided for in condition "1", vacate and set aside the stay order including any further stay imposed pursuant to Section 10175.2. Should no order vacating the stay be made pursuant to this condition or condition "4" below, the stay imposed herein shall become permanent.

4. Pursuant to Section 10148 of the Business and Professions Code, Respondent shall pay the Commissioner's reasonable cost for: a) the audit which led to this disciplinary action and, b) a subsequent audit to determine if Respondent has corrected the trust fund violation(s) found in paragraphs _____ of the Determination of Issues. In calculating the amount of the Commissioner's reasonable cost, the Commissioner may use the estimated average hourly salary for all persons performing audits of real estate brokers, and shall include an allocation for travel costs, including mileage, time to and from the auditor's place of work and per diem. Respondent shall pay such cost within 60 days of receiving an invoice from the Commissioner detailing the activities performed during the audit and the amount of time spent performing those activities. The Commissioner may, in his discretion, vacate and set aside the stay order, if payment is not timely made as provided for herein, or as provided for in a subsequent agreement between the Respondent and the Commissioner. The vacation and the set aside of the stay shall remain in effect until payment is made in full, or until Respondent enters into an agreement satisfactory to the Commissioner to provide for payment. Should no order vacating the stay be issued, either in accordance with this condition or condition "3", the stay imposed herein shall become permanent.

17. Trust Fund Violation Course Requirement.

Respondent shall, prior to and as a condition of the issuance of the restricted license, submit proof satisfactory to the Commissioner of having taken and successfully completed the continuing education course on trust fund accounting and handling specified in subdivision (a) of Section 10170.5 of the Business and Professions Code. Proof of satisfaction of this requirement includes evidence that respondent has successfully completed the trust fund account and handling continuing education course within 120 days prior to the effective date of the Decision in this matter.

18. Unlicensed Activity (Brokers and Salespersons) License Suspension with Right to Petition to Pay Monetary Penalty.

(a) In addition to any other penalty imposed, when a Respondent is found to have been compensated for performing acts requiring a real estate license without having a license or when his or her real estate license was suspended, revoked or expired, the penalty shall include a suspension of the license with the right to pay a monetary penalty to stay all or a portion of the suspension. The length of the suspension shall be based on the aggregate amount of compensation paid during the period of non-licensure measured by one (1) day of suspension for each one hundred dollars ($100) of compensation received up to a maximum of $10,000.00.)

(b) All licenses and licensing rights of Respondent _____ under the Real Estate Law are suspended for a period of _____ (____) days from the effective date of this Decision; provided, however, that if Respondent petitions, said suspension (or a portion thereof) shall be stayed upon condition that:

1. Respondent pays a monetary penalty pursuant to Section 10175.2 of the Business and Professions Code at the rate of $100.00 for each day of the suspension for a total monetary penalty of $_____.

2. Said payment shall be in the form of a cashier's check or certified check made payable to the Recovery Account of the Real Estate Fund. Said check must be received by the Department prior to the effective date of the Decision in this matter.

3. No further cause for disciplinary action against the real estate license of Respondent occurs within one year from the effective date of the Decision in this matter.

4. If Respondent fails to pay the monetary penalty in accordance with the terms and conditions of the Decision, the Commissioner may, without a hearing, order the immediate execution of all or any part of the stayed suspension in which event the Respondent shall not be entitled to any repayment nor credit, prorated or otherwise, for money paid to the Department under the terms of this Decision.

5. If Respondent pays the monetary penalty and if no further cause for disciplinary action against the real estate license of Respondent occurs within one year from the effective date of the Decision, the stay hereby granted shall become permanent.

19. Reporting Condition Criminal Conviction Cases (Brokers and Salespersons) — Restricted License.

In addition to any other penalty imposed, when a Respondent is found to have violated Sections 475(a)(2), 480(a)(1), 490 or 10177(b) of the Code, the following condition shall be included among the terms and conditions attached to a restricted license:

Respondent shall notify the Commissioner in writing within 72 hours of any arrest by sending a certified letter to the Commissioner at the Department of Real Estate, Post Office Box 187000, Sacramento, CA 95818-7000. The letter shall set forth the date of Respondent's arrest, the crime for which Respondent was arrested and the name and address of the arresting law enforcement agency. Respondent's failure to timely file written notice shall constitute an independent violation of the terms of the restricted license and shall be grounds for the suspension or revocation of that license.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10148 and 10153.4, Business and Professions Code; and Section 11425.50, Government Code.

HISTORY

1. New article 18.7 (section 2930) and section filed 12-30-97; operative 1-29-98 (Register 98, No. 1).
2. Amendment filed 10-26-99; operative 11-25-99 (Register 99, No. 44).
3. Editorial correction of item 16 (Register 2000, No. 45).
4. Amendment of item 11.2. and amendment of NOTE filed 11-9-2000; operative 12-9-2000 (Register 2000, No. 45).
5. Amendment of section and NOTE filed 6-20-2002; operative 7-20-2002 (Register 2002, No. 25).
6. Amendment of item 16. and new items 17.-18.(b)5. filed 9-5-2003; operative 10-5-2003 (Register 2003, No. 36).
7. Amendment of items 6. and 14. and amendment of NOTE filed 3-17-2005; operative 4-16-2005 (Register 2005, No. 11).
8. Amendment adding item 19. filed 2-28-2006; operative 3-30-2006 (Register 2006, No. 9).

Article 18.8. Voluntary Surrender of License

§ 2940. Petition for Voluntary Surrender of License.

(a) A licensee may petition the commissioner under Section 10100.2 of the Code to accept the voluntary surrender of his or her real estate license or license rights. The petition shall be in writing and shall contain the following:

(1) A reference to the investigation or accusation giving rise to the petition.

(2) An identification of the real estate licenses or license rights held by the petitioner.

(3) An acknowledgment that the petitioner has read and agrees to the following as a condition of the commissioner's acceptance of the petition:

The filing of a petition shall be deemed to be an understanding and agreement by the licensee that upon acceptance by the commissioner all affidavits obtained in the investigation prior to the acceptance and all allegations contained in an accusation filed pursuant to Section 11503 of the Government Code may be considered by the Department to be true and correct for the purpose of deciding whether or not to grant reinstatement of the license.

(b) Acceptance of a petition to surrender a license shall be pursuant to an Order issued by the commissioner. The commissioner may refuse to accept a surrender of a license if it is determined in the exercise of his or her discretion, that it would not be in the public interest to accept the surrender.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10100.2, Business and Professions Code.

HISTORY

1. New article 18.8 (section 2940) and section filed 12-30-97; operative 1-29-98 (Register 98, No. 1).

Article 19. Escrows

§ 2950. When Broker Handles Escrow.

The following acts in the handling of an escrow by a real estate broker exempted from the provisions of the Escrow Law (by Section 17006(a)(4) of the Financial Code) are prohibited and may be considered grounds for disciplinary action:

(a) Soliciting or accepting an escrow instruction (or amended or supplemental escrow instruction) containing any blank to be filled in after signing or initialing of such escrow instruction (or amended or supplemental escrow instruction).

(b) Permitting any person to make any addition to, deletion from, or alteration of an escrow instruction (or amended or supplemental escrow instruction) received by such licensee, unless such addition, deletion or alteration is signed or initialed by all persons who had signed or initialed such escrow instruction (or amended or supplemental escrow instruction) prior to such addition, deletion or alteration.

(c) Failing to deliver at the time of execution of any escrow instruction or amended or supplemental escrow instruction a copy thereof to all persons executing the same.

(d) Failing to maintain books, records and accounts in accordance with accepted principles of accounting and good business practice.

(e) Failing to maintain the office, place of books, records, accounts, safes, files, and papers relating to such escrows freely accessible and available for audit, inspection and examination by the commissioner.

(f) Failing to deposit all money received as an escrow agent and as part of an escrow transaction in a bank, trust account, or escrow account on or before the close of the next full working day after receipt thereof.

(g) Withdrawing or paying out any money deposited in such trustee account or escrow account without the written instruction of the party or parties paying the money into escrow.

(h) Failing to advise all parties in writing if he has knowledge that any licensee acting as such in the transaction has any interest as a stockholder, officer, partner or owner of the agency holding the escrow.

(i) Failing upon closing of an escrow transaction to render to each principal in the transaction a written statement of all receipts and disbursements together with the name of the person to whom any such disbursement is made.

(j) Delivering or recording any instrument which purportedly transfers a party's title or interest in or to real property without first obtaining the written consent of that party to the delivery or recording.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10145, Business and Professions Code; and Section 17006(a)(4), Financial Code.

HISTORY

1. New Article 19 (§2950) filed 12–11–57; effective thirtieth day thereafter (Register 57, No. 22).
2. Amendment filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).
3. New subsection (j) filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
4. Amendment of first paragraph and NOTE filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).

§ 2951. Record Keeping and Funds Handling.

The provisions of Sections 2831, 2831.1, 2831.2, 2832, 2832.1, 2834 and 2835 of these regulations shall apply to the handling of funds and the keeping of records by a real estate broker who is not licensed under the Escrow Law (Section 17000, et seq., of the Financial Code) when acting in the capacity of an escrow holder in a real estate purchase and sale, ex-

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change or loan transaction in which the broker is performing acts for which a real estate license is required.

NOTE: Authority cited: Section 10080. Business and Professions Code. Reference: Sections 10145 and 10148, Business and Professions Code; and Section 17006 (d), Financial Code.

HISTORY

1. New section filed 12–1–81; designated effective 1–1–82 (Register 81, No. 49).
2. Amendment filed 1–9–85; effective thirtieth day thereafter (Register 85, No. 2).
3. Amendment of section and NOTE filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
4. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 20. Land Locators

§ 2960. Land Locator Contract.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10140 and 10144, Business and Professions Code.

HISTORY

1. New Article 20 (2690) filed 7–22–59 as an emergency; effective upon filing (Register 59, No. 12).
2. Certificate of Compliance—Section 11422.1, Government Code, filed 9–16–59 (Register 59, No. 16).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 21. Advance Fee Agreements

§ 2970. Advance Fee Materials.

(a) A person who proposes to collect an advance fee as defined in Section 10026 in the Code shall submit to the Commissioner not less than ten calendar days before publication or other use, all materials to be used in advertising, promoting, soliciting and negotiating an agreement calling for the payment of an advance fee including the form of advance fee agreement proposed for use.

(b) Material used in advertising, promoting, soliciting and negotiating an advance fee agreement shall not be approved if it:

(1) Includes any representation which is false, misleading or deceptive.

(2) Does not set forth a specific, complete description of the services to be rendered for the advance fee.

(3) Does not set forth the total amount of the advance fee along with the date on which the fee shall become due and payable.

(4) Contains any provision which purports to relieve or exempt the person collecting the advance fee from an obligation to fulfill verbal commitments and representations made by employees and agents of the person contracting for the advance fee.

(5) Contains any provision which purports to give a guarantee that the real property or business opportunity in question will be purchased, leased or exchanged or that a loan secured by real property will be obtained as a result of the services rendered by the person collecting the advance fee.

(6) Does not set forth a definite date for full performance of the services promised under the advance fee agreement.

(c) Not less than 10–point type shall be used in advance fee agreements.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10026 and 10085, Business and Professions Code.

HISTORY

1. New Article 21 (Sections 2970 through 2974) filed 9–18–59 as an emergency; effective upon filing (Register 59, No. 16).
2. Certificate of Compliance—Sec. 11422.1, Gov. Code for Article 21 (Sections 2970–2974), filed 12–15–59 (Register 59, No. 21).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment of subsection (a) filed 4–1–93; operative 5–1–93 (Register 93, No. 14).

§ 2971. Form of Advance Fee Agreements.

HISTORY

1. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2972. Accounting Content.

Each verified accounting to a principal or to the commissioner as required by Section 10146 of the Code shall include at least the following information:

(a) The name of the agent.

(b) The name of the principal.

(c) Description of the services rendered or to be rendered.

(d) Identification of the trust fund account into which the advance fee has been deposited.

(e) The amount of the advance fee collected.

(f) The amount allocated or disbursed from the advance fee for each of the following:

(1) In providing each of the services enumerated under (c) above.

(2) Commissions paid to field agents and representatives.

(3) Overhead costs and profit.

(g) In cases in which disbursements has been made for advertising, a copy of the advertisement, the name of the publication, the number of the advertisements actually published and the dates that they were carried.

(h) In the case of an advance fee for the arrangement of a loan secured by a real property or a business opportunity, a list of the names and addresses of the persons to whom information pertaining to the principal's loan requirements were submitted and the dates of the submittal.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10146, Business and Professions Code.

HISTORY

1. Amendment filed 9–17–65; designated effective 1–2–66 (Register 65, No. 17).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2973. Retention of Advance Fee Records.

HISTORY

1. Amendment filed 9–17–65; designated effective 1–2–66 (Register 65, No. 17).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2974. Advance Fee Statement of Account Required.

HISTORY

1. Amendment filed 9–17–65; designated effective 1–2–66 (Register 65, No. 17).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

Article 22. Real Property Securities Dealers

§ 2975. Application for Permit.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10238.4, Business and Professions Code.

HISTORY

1. New Article 22 (Sections 2975 through 2980) filed 7–5–61 as an emergency; effective on filing (Register 61, No. 13).
2. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment of subsections (a) and (b)(2) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
5. Repealer of article 22 and section filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2975.1. Application for Permit, Contents Of.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2975.2. Permit Application: If Applicant Is a Principal.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2975.3. Supplementary Filings.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).

2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2976. Permit Duration.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10238.4, Business and Professions Code.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Amendment filed 9–17–65; effective thirtieth day thereafter (Register 65, No. 17).
3. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Repealer filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2976.1. Use of Permit in Advertising.

HISTORY

1. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2976.2. Permit Is Not an Endorsement.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2977. Annual Reports.

NOTE: Authority cited: Sections 10080 and 10238.1(b), Business and Professions Code. Reference: Section 10238.1, Business and Professions Code.

HISTORY

1. New section filed 5–4–89; operative 6–3–89 (Register 89, No. 23). For prior history, see Register 86, No. 4.
2. Repealer filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2977.1. Approval of Submitted Securities Dealer's Statement Forms.

HISTORY

1. Repealer filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).

§ 2977.2. Type Size for Dealer's Statement Form.

NOTE: Authority cited: Sections 10080 and 10238.1(b), Business and Professions Code. Reference: Section 10238.1, Business and Professions Code.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Repealer of section and new NOTE filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2978. Advertising.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10235 and 10237.7, Business and Professions Code.

HISTORY

1. Amendment filed 5–13–82; effective thirtieth day thereafter (Register 82, No. 20).
2. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of subsection (a), repealer of subsection (b), and subsection relettering filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
4. Repealer filed 12–30–97; operative 1–29–98 (Register 98, No. 1).

§ 2978.1. Advertising Material to Be Submitted.

HISTORY

1. New section filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Repealer filed 8–21–63; designated effective 9–20–63 (Register 63, No. 14).

§ 2978.2. Real Property Securities Dealer. Use of Designation in Advertising.

HISTORY

1. New section filed 11–21–61; effective thirtieth day thereafter (Register 61, No. 23).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

§ 2979. Term of Securities Dealer Endorsement.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10224 and 10237.3, Business and Professions Code.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Amendment filed 8–3–66; effective thirtieth day thereafter (Register 66, No. 25).
3. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2979.1. Securities Dealer's Endorsement for Corporate Broker.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10158, 10211 and 10224, Business and Professions Code.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Amendment filed 3–1–68; effective thirtieth day thereafter (Register 68, No. 9).
3. Amendment filed 10–14–68; effective thirtieth day thereafter (Register 68, No. 39).
4. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
5. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 2980. Bonds Pledged in Lieu of Surety Bond.

HISTORY

1. Amendment filed 7–31–61 as an emergency; effective on filing. Certificate of Compliance filed 8–4–61 (Register 61, No. 15).
2. Repealer filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).

Article 23. Real Estate Syndicate Securities

NOTE: Authority cited: Sections 10080, 10249.2, and 11011.8, Business and Professions Code.

HISTORY

1. Repealer of Article 23 (Sections 2990–2999.6, not consecutive) filed 1–16–79; effective thirtieth day thereafter (Register 79, No. 3). For prior history, see Register 69, No. 50.

Article 24. Private Vocational School and Supervised Course of Study Approvals

§ 3000. Equivalent Courses of Study at Private Vocational Schools.

(a) In making a determination under authority of section 10153.5 of the Code as to whether a course of study at a private vocational school is equivalent in quality to real estate courses offered by colleges and universities accredited by the Western Association of Schools and Colleges, the commissioner shall consider, but shall not be limited to the following criteria:

(1) An attended course must provide at least 45 periods of classroom instruction, each of which shall be not less than 50 minutes duration. A correspondence course shall consist of not less than 15 separate lesson assignments.

(2)(A) An attended course must provide for a final examination administered and supervised by the school in a classroom setting.

(B) A correspondence course must provide for a final examination administered and supervised by a person designated by the school for that purpose. The school shall send the final examination materials to the person so designated and the completed final examination shall be returned to the school by the person so designated.

(3) The school must provide instructors, instructional material and classroom facilities adequate to achieve the objective of the course offered.

(4) The school shall maintain records for each student sufficient to allow for the preparation of a duplicate certificate upon request by a student.

(5) The school shall not use advertising or other promotional devices that are deceptive or misleading.

(6) The school shall, within 15 days of a student's successful completion of the course, deliver a document to the student evidencing such completion. The document shall contain the following information:

(A) Department of Real Estate course approval number.

(B) Name of student.

(C) Course title.

(D) Dates of course completion.

(E) Name and address of school.

The school may include such additional information in this document as it deems necessary.

(7) The school shall have an appropriate method of assessing student knowledge of the subject, such as, but not limited to, multiple choice, essay or oral examinations.

(8) Instructors must have credentials issued by the Board of Governors of the California Community Colleges or by a comparable California teacher-credentialing agency or meet the qualifications established in Sections 53400 et seq. of Title 5. The commissioner may approve instructors who in his or her judgment meet the qualifications, or who otherwise evidence their teaching qualifications by education or experience or a combination of the two. An instructor shall not teach a course if the instructor:

(A) Does not satisfy the criteria in this subdivision.

(B) Has engaged in any violation of Article 24 (commencing with Section 3000) of these regulations or has engaged in conduct which would have warranted the denial of an application for approval or withdrawal of approval of an equivalent course of study.

(C) As a real estate licensee has had that license suspended, revoked or restricted as a result of disciplinary action.

(D) Acted or conducted himself or herself in a manner which would have warranted the denial of his or her application for a real estate license.

(9) Beginning on January 1, 2004, the school shall notify each student that an evaluation form is available on the Department's internet website for on-line evaluation of courses and instructors.

(b) The simultaneous instruction of two or more students in one of the courses enumerated in sections 10153.2, 10153.3 or 10153.4 of the Code constitutes a "private vocational school" as that term is used in section 10153.5.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10153.5, Business and Professions Code.

HISTORY

1. New section filed 12-10-71; designated effective 3-6-72 (Register 71, No. 50).
2. Amendment filed 1-17-80; effective thirtieth day thereafter (Register 80, No. 3).
3. Editorial correction in subsection (c) (Register 80, No. 28).
4. Amendment of subsection (c) filed 12-1-81; designated effective 1-1-82 (Register 81, No. 49).
5. Repealer and new section filed 7-1-83; effective thirtieth day thereafter (Register 83, No. 30).
6. Amendment of subsection (a)(1) filed 1-11-84; effective thirtieth day thereafter (Register 84, No. 2).
7. Amendment of subsection (a) filed 4-2-86; effective thirtieth day thereafter (Register 86, No. 14).
8. Amendment filed 11-16-87; operative 12-16-87 (Register 87, No. 47).
9. Amendment of subsection (a) filed 5-4-89; operative 6-3-89 (Register 89, No. 23).
10. Amendment of subsections (a) and (b) filed 7-12-91; operative 8-11-91 (Register 91, No. 44).
11. New subsections (a)(2)-(5) and subsection renumbering to subsections (a)(6)-(12) filed 4-7-92; operative 5-7-92 (Register 92, No. 14).
12. Amendment filed 11-13-96; operative 11-13-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
13. Amendment of subsection (a)(4) filed 12-30-97; operative 1-29-98 (Register 98, No. 1).
14. New subsections (a)(8)-(9) filed 9-5-2003; operative 10-5-2003 (Register 2003, No. 36).

§ 3001. Supervised Courses of Study.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10153.2, 10153.4 and 10153.5, Business and Professions Code.

HISTORY

1. New section filed 12-10-71; designated effective 3-6-72 (Register 71, No. 50).
2. Repealer and new section filed 7-1-83; effective thirtieth day thereafter (Register 83, No. 30).
3. Repealer filed 11-13-96; operative 11-13-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3002. Application and Fee.

(a) A person making application for approval by the commissioner of an equivalent course of study within the meaning of Sections 10153.2, 10153.4 or 10153.5 of the Code shall make application on a form prescribed by the Department and shall include therein such relevant information as the commissioner may require. The application shall be accompanied by the appropriate fee as provided in subdivision (c) hereof and include at least the following:

(1) The name, address and telephone number of the applicant.

(2) Summary of the course including:

(A) Type of course (resident lecture or correspondence/independent study).

(B) Course title.

(C) Complete course outline or syllabus with time schedule indicating total number of hours for course.

(D) Textbook(s) and student materials prescribed.

(E) Evidence of Private Vocational School approval or registration by the Bureau for Private Postsecondary and Vocational Education of the California Department of Consumer Affairs if the sponsor is not otherwise exempt from the requirement for such approval or registration or by the appropriate approval authority of the state in which the school is located shall be included with the course application.

(b) Any material change to an approved equivalent course of study shall be submitted by the school to the Department for approval prior to use.

A material change for purposes of this section is a deviation from an equivalent course of study approved by the Department, including a change in curriculum, course length, workbooks, texts or syllabi, but not including changes designed exclusively to reflect recent changes in statutes, regulations or decisional law.

(c) The fees for applications for approval of equivalent courses of study under Sections 10153.2, 10153.3 and 10153.4 of the Code and for material changes to previously approved courses shall be the fees prescribed in Section 10209 of the Code.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10153.5, Business and Professions Code.

HISTORY

1. New section filed 12-10-71; designated effective 3-6-72 (Register 71, No. 50).
2. Repealer and new section filed 7-1-83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment filed 11-16-87; operative 12-16-87 (Register 87, No. 47).
4. Amendment including new subsections (a)(1)-(6) and (b) and subsection relettering filed 5-26-92; operative 6-25-92 (Register 92, No. 22).
5. Amendment filed 11-27-96; operative 12-27-96 (Register 96, No. 48).
6. Amendment of subsection (a)(2)(E) filed 10-26-99; operative 11-25-99 (Register 99, No. 44).

§ 3003. Course Disapproval.

(a) If the commissioner determines that a course of study previously approved as equivalent is no longer equivalent in quality to courses offered by colleges and universities accredited by the Western Association of Schools and Colleges, or if the commissioner determines that an instructor or lecturer for the course is no longer qualified, or that the course sponsor has engaged in activity violating the provisions of Section 3004, the commissioner shall give written notice of withdrawal of approval setting forth the reasons for the determination. If the commissioner determines, following an application for course approval, that the course will not provide applicants for real estate broker or real estate salesperson licenses with knowledge and understanding equivalent to that provided through courses offered by colleges and universities accredited by the Western Association of Schools and Colleges or if the commissioner determines that the instructor for the course is unqualified, the commissioner shall give written notice of denial of approval setting forth the reasons

for the determination. Withdrawal or denial of approval will be effective 30 days after the notice of withdrawal or denial is received by the sponsor unless the sponsor earlier files a written request for hearing on the withdrawal or denial action. If the request for hearing is received by the commissioner before 30 days after the date of receipt of notice of withdrawal by the sponsor, the withdrawal or denial of approval shall not be effective unless and until ordered by the commissioner pursuant to findings and conclusions reached after hearing pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The hearing shall be commenced within 30 days after receipt of the request for hearing unless continued to a later date by order of the commissioner or by agreement of the parties. In a hearing on an order of withdrawal issued by the commissioner, the burden of proving that the course is no longer equivalent in quality shall be on the commissioner. In any hearing on an order of denial issued by the commissioner, the burden of proving the equivalency of the proposed course of study shall be on the applicant.

(b) Petition for Reinstatement.

(1) The sponsor of an offering for which approval has been withdrawn pursuant to subdivision (a) may, after a period of not less than one year has elapsed from the effective date of the withdrawal of approval, petition the commissioner in writing for reinstatement of approval of the offering. The petitioner shall be given the opportunity to present in writing argument and other evidence, statements or matters in support of the petition. The commissioner shall decide the petition and the decision shall include the reasons therefor.

(2) Upon a showing of good cause, the commissioner may allow the filing of a petition for reinstatement prior to the expiration of one year from the effective date of the withdrawal of approval.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10153.5 and 10177, Business and Professions Code.

HISTORY

1. New section filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of subsection (a) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
4. Amendment filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
5. Amendment of subsection (c)(1) and NOTE filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
6. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
7. New subsection (a) designator, new subsections (b)–(b)(2) and amendment of NOTE filed 10–26–99; operative 11–25–99 (Register 99, No. 44).

§ 3004. Advertising and Promotion of Equivalent Courses of Study.

The use of advertising or promotional material by or on behalf of the private vocational school or other sponsor of an equivalent course of study will be considered by the commissioner to be deceptive or misleading if it does not comply with the following standards:

(a) An advertisement shall clearly and conspicuously identify the entity offering an equivalent course of study as a private vocational school or the sponsor of a supervised course of study or other approved equivalent course of study and shall include the name of the entity.

(b) Advertising which makes reference to courses of study approved by the commissioner shall identify the specific course or courses that have been approved by listing the Department's course approval number.

(c) No advertising or materials, including oral representations, promoting approved equivalent courses shall contain language which implies or states, directly or indirectly, that a course can be completed in less time than the number of hours for which it is approved.

(d) No advertising or materials, including oral representation, shall include false or misleading statements or representations.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10153.5, Business and Professions Code.

HISTORY

1. New section filed 12–10–71; designated effective 3–6–72 (Register 71, No. 50).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment of subsection (e) and new subsection (g) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
4. Amendment of subsections (a) and (b) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).
5. Amendment of subsection (g) and new subsections (h)–(j) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
6. Amendment of subsections (d) and (j) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
7. Amendment of first paragraph, repealer of subsections (a)–(c), (f)–(h) and (j), subsection relettering, amendment of newly designated subsection (c), and new subsection (d) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

Article 25. Continuing Education Requirements

§ 3005. Definitions.

As used in this article, the following definitions will apply:

(a) "Clock hours" means 50 minutes actually spent in any combination of presenting course content, seminar, conference discussions, or workshop activity.

(b) "Approval" or "approved" with reference to an offering means a determination by the Department that the appropriate hours of continuing education credit will be given to licensees who have successfully completed the course within the time period specified by statute.

(c) "Final examination" means the test by which the sponsor, after completion of a continuing education offering, determines whether a participant has successfully completed the offering according to standards previously approved by the Department.

(d) "Material change" as used in Section 3007.2 means a significant deviation, in one or more aspects, from the offering as approved by the Department including a change in curriculum, course length, method of presentation, workbooks, texts, or syllabi, but not including changes designed exclusively to reflect recent changes in statutes, regulations or decisional law.

(e) "Completed" as used in Sections 3006, 3006.1, and 3013 in reference to a continuing education offering, means the date of successful completion of a final examination.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27). For history of former Section 3005, see Registers 83, No. 30; and 77, No. 49.
2. Amendment of subsection (a), repealer of subsections (d), (f), (i) and (j), subsection relettering, and amendment of newly designated subsection (d) filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
3. Amendment filed 7–31–98; operative 8–30–98 (Register 98, No. 31).
4. Amendment of subsections (c)–(e) filed 8–29–2007; operative 2–29–2008 (Register 2007, No. 35).

§ 3005.1. Access to Offerings.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.4, Business and Professions Code.

HISTORY

1. New section filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27).
2. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3006. Criteria for Approval of Offerings.

In acting on an application for approval of a continuing education offering, the commissioner shall apply, but shall not be limited to the application of, the following criteria:

(a) The offering shall have at least one successive clock hour of instruction.

(b) For other than a correspondence course offering, participants shall be physically present.

(c) For other than a correspondence course offering, a sponsor shall provide written materials, including a course outline, to each student. The written course outline shall consist of not less than three pages for each clock hour of instruction.

(d) A continuing education offering shall have an appropriate form of final examination, such as, but not limited to, multiple choice, essay or oral examinations.

(e) Instructors, conference leaders, lecturers, and others who present a continuing education requirement offering shall meet at least one of the following qualifications:

(1) A bachelor's degree in a related field to that in which the person is to teach, from a school listed as an institution of higher learning by the U.S. Department of Education, or from a comparable school of a foreign country.

(2) A valid teaching credential or certificate issued by the Board of Governors of the California Community Colleges or by a comparable California teacher–credentialing agency authorizing the holder to teach in the field of knowledge covered in the offering.

(3) Three years full–time experience in the applicable field.

(4) Any combination of at least three years of full–time experience and college level education in the applicable field.

(5) The commissioner may approve instructors who in his or her judgment meet the criteria for approval or who otherwise evidence their teaching qualifications by education or experience or a combination of the two.

(f) An instructor shall not be qualified if the instructor:

(1) Does not satisfy the criteria in subdivision (e).

(2) Has engaged in any violation of Article 25 (commencing with Section 3005) of these regulations or has engaged in conduct which would have warranted the denial of an application for approval or withdrawal of approval of a continuing education offering.

(3) As a real estate licensee has had that license suspended, revoked or restricted as a result of disciplinary action.

(4) Acted or conducted himself or herself in a manner which would have warranted the denial of his or her application for a real estate license.

(g) A correspondence course shall consist of adequate study materials to assure that the course cannot be completed in less time than the number of hours for which it is approved.

(h) Every sponsor shall maintain on file with the commissioner a current address.

(i) Beginning on January 1, 2004, the sponsor shall notify each student that an evaluation form is available on the Department's internet website for on–line evaluation of courses and instructors.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. Amendment of subsection (b)(2)(G) filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
2. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
3. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment filed 1–11–84; effective thirtieth day thereafter (Register 84, No. 2).
5. Amendment filed 9–12–84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 37).
6. Amendment filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
7. Amendment filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
8. Amendment of subsection (g)(2)(B) filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
9. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
10. Amendment of subsection (c) and NOTE filed 7–31–98; operative 8–30–98 (Register 98, No. 31).
11. New subsections (c), (e)–(f)(4) and (i), repealer of subsection (d) and subsection relettering filed 9–5–2003; operative 10–5–2003 (Register 2003, No. 36).
12. Amendment of subsection (d) filed 8–29–2007; operative 2–29–2008 (Register 2007, No. 35).

§ 3006.1. Expiration of Approval.

If an offering had approval at the time of registration by a licensee, credit for the offering shall be given to the licensee at the time of license renewal notwithstanding the fact that approval had expired and had not been renewed or reinstated at the time that the applicant successfully completed the offering.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.6, Business and Professions Code.

§ 3007. Application for Offering Approval.

An application for approval of a continuing education offering shall be made on a form prescribed by the Department not less than 90 days before the proposed commencement date of the offering. The application shall be accompanied by the fee and include at least the following:

(a) The name, address and telephone number of the applicant.

(b) Summary of the offering including:

(1) Title.

(2) Textbook(s) and student materials prescribed.

(3) Outline or syllabus.

(4) A statement whether the offering is intended to comply with Business and Professions Code section 10170.5(a)(1), (2), (3), (4), (5) or (6).

(5) Disclosure of the method of offering presentation.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. Amendment of subsection (d)(13) filed 1–17–80; effective thirtieth day thereafter (Register 80, No. 3).
2. Amendment filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
3. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
4. Amendment filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27).
5. Amendment of subsection (d) (6), (d) (8) and (d) (11) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
6. Amendment of subsection (d) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
7. Amendment of subsection (d)(11) and NOTE filed 12–7–94; operative 1–6–95 (Register 94, No. 49).
8. Amendment filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3007.05. Forms of Identification Accepted.

A participant shall present one of the following forms of identification immediately before admittance to a live presentation of an offering or, immediately before the administration of the final examination for a correspondence offering.

(a) A current California drivers license.

(b) A current identification card described in Section 13000 of the California Vehicle Code.

(c) Any identification of the participant issued by a governmental agency or a recognized real estate related trade organization within the immediately preceding five years which bears a photograph, signature and identification number of the participant.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.4, Business and Professions Code.

HISTORY

1. New section filed 8–29–2007; operative 2–29–2008 (Register 2007, No. 35).

§ 3007.1. Submittal of Audio Tapes.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.4, Business and Professions Code.

HISTORY

1. New section filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27). For history of former Section 3007.1, see Registers 83, No. 30; and 78, No. 17.
2. Repealer filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3007.2. Material Change in Course Offering.

(a) Any proposed material change to an approved offering shall be submitted by the sponsor to the Department for consideration and approval prior to use.

(b) A material change as defined in Section 3005(d) shall require a new application and fee.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 8–29–2007; operative 2–29–2008 (Register 2007, No. 35). For prior history, see Register 96, No. 46.

§ 3007.3. Final Examination Rules.

(a) Sponsors shall establish and participants shall observe the following final examination rules for approved offerings:

(1) The final examination shall provide for the testing, examination or evaluation of participants. The sponsor shall take steps to protect the integrity of the examination and to prevent cheating in an examination.

(2) The examination shall not be taken by participants until completion of the instructional portion of the offering to which the examination applies.

(3) Participants taking a correspondence offering shall be limited to completion of final examinations for that offering for a maximum of fifteen credit hours during any one 24 hour period.

(b) A violation of a final examination rule by the sponsor or the sponsor's representative administering the examination shall constitute grounds for denial or withdrawal of approval of the offering.

(c) To pass the examination, a participant must achieve a percentage score of 70 percent or more.

(d) Time involved in the final examination process may be included in establishing "clock-hours" for the offering.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.4, Business and Professions Code.

HISTORY

1. New section filed 10-1-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 40).
2. Amendment of subsection (a) filed 5-4-89; operative 6-3-89 (Register 89, No. 23).
3. Repealer of subsections (a)(1)-(a)(4), (a)(6) and (a)(8)-(a)(15), new subsection (a)(1), and subsection renumbering filed 11-13-96; operative 11-13-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).
4. Amendment of section heading and section filed 7-31-98; operative 8-30-98 (Register 98, No. 31).
5. Amendment of section heading and subsections (a) and (a)(2) and new subsections (a)(3) and (c)-(d) filed 8-29-2007; operative 2-29-2008 (Register 2007, No. 35).

§ 3007.4. Offerings Approved Before Final Examination or Evaluation Requirement.

NOTE: Authority cited: Sections 10080, and 10170.4, Business and Professions Code. Reference: Sections 10170.4, and 10170.6, Business and Professions Code.

HISTORY

1. New section filed 7-5-84; designated effective 8-1-84 (Register 84, No. 27).
2. Repealer filed 5-4-89; operative 6-3-89 (Register 89, No. 23).

§ 3007.5. Consumer Protection Courses.

NOTE: Authority cited: Sections 10080, and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 7-5-84; designated effective 8-1-84 (Register 84, No. 27).
2. Amendment filed 5-4-89; operative 6-3-89 (Register 89, No. 23).
3. Repealer filed 12-7-94; operative 1-6-95 (Register 94, No. 49).

§ 3007.6. Advertising and Promotional Material.

(a) All advertising and promotional material for a continuing education offering shall:

(1) Not include false or misleading statements or representations.

(2) Classify the offering in accordance with Section 10170.5(a) of the Code.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 2-26-85; effective thirtieth day thereafter (Register 85, No. 9).
2. New subsection (a)(6) filed 3-18-88; operative 4-17-88 (Register 88, No. 14).
3. Amendment of subsection (a)(3) and new subsections (c) and (d) filed 5-4-89; operative 6-3-89 (Register 89, No. 23).
4. New subsections (a)(3)(C)-(D) and subsection redesignation filed 12-7-94; operative 1-6-95 (Register 94, No. 49).
5. Amendment filed 11-13-96; operative 11-13-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3008. Offerings Not to Be Approved.

The commissioner shall not approve a proposed continuing education offering that includes any of the following subject matter or conditions:

(a) Offerings which do not address the subject matter areas set forth in Business and Professions Code section 10170.5.

(b) Sales promotion.

(c) That portion of any offering devoted to the consuming of meals or to transporting participants to and from sites to be viewed or inspected as part of the offering.

(d) Any offering for which approval has been denied or withdrawn pursuant to section 3010.

(e) Any offering substantially similar to and offered by the sponsor of an offering for which approval has been denied or withdrawn pursuant to section 3010.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. Amendment filed 7-1-83; effective thirtieth day thereafter (Register 83, No. 30).
2. Amendment filed 1-11-84; effective thirtieth day thereafter (Register 84, No. 2).
3. Amendment filed 7-5-84; designated effective 8-1-84 (Register 84, No. 27).
4. Amendment of subsection (b) filed 4-2-86; effective thirtieth day thereafter (Register 86, No. 14).
5. Amendment filed 3-18-88; operative 4-17-88 (Register 88, No. 14).
6. Amendment of subsection (b) filed 7-12-91; operative 8-11-91 (Register 91, No. 44).
7. Repealer of subsections (a), (d), (f) and (i), subsection relettering, and amendment of newly designated subsection (b) filed 11-13-96; operative 11-13-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3009. Fees.

(a) Approval by the Department of a continuing education offering shall be for a term of two years from the date of approval or from a date specified by the Department in granting the approval. The fee for processing the application for approval of an offering of three or more hours duration shall be $500. The fee for processing the application for approval of an offering of less than three hours duration shall be $350.

(b) The fee for processing a petition for continuing education credit based upon a claim of equivalency by the petitioner pursuant to subdivision (c) of Section 10170.4 of the Code shall be $60.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. Amendment filed 12-3-80; effective thirtieth day thereafter (Register 80, No. 49).
2. Amendment filed 1-7-81; effective thirtieth day thereafter (Register 81, No. 2).
3. Repealer and new section filed 7-1-83; effective thirtieth day thereafter (Register 83, No. 30).
4. Repealer and new section filed 1-9-85; effective thirtieth day thereafter (Register 85, No. 2).
5. Amendment of subsection (a) filed 7-31-98; operative 8-30-98 (Register 98, No. 31).

§ 3010. Denial or Withdrawal of Approval.

(a) If the commissioner determines that a previously-approved continuing education offering no longer meets the prescribed statutory and regulatory standards for approval, or if the commissioner determines that an instructor or lecturer for the course is no longer qualified, or that the course sponsor has engaged in activity violating the provisions of Article 25 (commencing with section 3005) of these regulations or has engaged in conduct which would have warranted the denial of an application for approval or withdrawal of approval of a continuing education offering, or the course differs materially from that which was previously approved, the commissioner shall give written notice of withdrawal of approval setting forth the reasons for the determination. If the commissioner determines, following an application for course approval, that the course will not meet the prescribed statutory and regulatory standards for approval or if the commissioner determines that the instructor for the course is unqualified, the commissioner shall give written notice of denial of approv-

al setting forth the reasons for the determination. Withdrawal or denial of approval will be effective 30 days after the notice of withdrawal or denial is received by the sponsor unless the sponsor earlier files a written request for hearing on the withdrawal or denial action. If the request for hearing is received by the commissioner before 30 days after the date of receipt of notice of withdrawal by the sponsor, the withdrawal or denial of approval shall not be effective unless and until ordered by the commissioner pursuant to findings and conclusions reached after hearing pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The hearing shall be commenced within 30 days after receipt of the request for hearing unless continued to a later date by order of the commissioner or by agreement of the parties. In a hearing on an order of withdrawal issued by the commissioner, the burden of proving that the course does not meet the prescribed statutory and regulatory standards for approval shall be on the commissioner. In a hearing on an order of denial issued by the commissioner, the burden of proving that the course meets the prescribed statutory and regulatory standards for approval shall be on the applicant.

(b) Petition for Reinstatement.

(1) The sponsor of an offering for which approval has been withdrawn pursuant to subdivision (a) may, after a period of not less than one year has elapsed from the effective date of the withdrawal of approval, petition the commissioner in writing for reinstatement of approval of the offering. The petitioner shall be given the opportunity to present in writing argument and other evidence, statements or matters in support of the petition. The commissioner shall decide the petition and the decision and the decision shall include the reasons therefor.

(2) Upon a showing of good cause, the commissioner may allow the filing of a petition for reinstatement prior to the expiration of one year from the effective date of the withdrawal of approval.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.4, Business and Professions Code.

HISTORY

1. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
2. Amendment filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27).
3. Amendment filed 3–18–88; operative 4–17–88 (Register 88, No. 14).
4. Amendment of subsection (a), new subsection (b) and subsection redesignation, and amendment of newly designated subsections (g)(1) and (g)(2) filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
5. Repealer of subsections (a)–(f)(2), new subsection (a), subsection relettering, and amendment of newly designated subsections (b)(1) and (b)(2) filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3010.5. Determination of Qualifications of Instructor.

NOTE: Authority cited: Sections 10080 and 10170.4, Business ant Professions Code. Reference: Section 10170.4(b), Business and Professions Code.

HISTORY

1. New section filed 3–18–88, operative 4–17–88 (Register 88, No. 14).
2. Amendment of subsection (a) filed 11–8–93; operative 12–8–93 (Register 93, No. 46).
3. Repealer of section and amendment of NOTE filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3011. Equivalent Activities Criteria.

(a) The primary consideration in determining whether a specific activity qualifies as an acceptable alternative to attendance at approved continuing education offerings is that it must include either presentation, development, authorship or research of information and materials designed to contribute directly to assuring that licensees maintain a reasonable currency of knowledge as a basis for a level of real estate practice as set forth in Business and Professions Code Section 10170.4.

(b) Equivalent activities may include but not be limited to:

(1) Attendance at courses not approved by the Commissioner.

(2) Instructing others in approved continuing education for real estate license renewal.

(3) Instruction or presentation of real estate related topics if the petitioner can demonstrate that the material conveyed contained reasonably current information designed to assist real estate licensees in providing a high level of consumer protection or service.

(4) Authorship of published professional articles, periodicals or books on current real estate procedures and law.

(c) Activities engaged in during the course of a licensee's normal occupation shall not be acceptable for a claim of equivalency unless such activities comply with subsections (a) and (b).

(d) Development of real estate education programs shall be given continuing education credit if the program would otherwise meet the requirements necessary for approval for continuing education credit.

(1) Sole authorship or development of a real estate educational program shall be credited upon an approved petition, with two hours continuing education credit for each hour of the program entitled to continuing education credit.

(2) Multiple authorship and development of a real estate educational program shall be credited, upon approval of a petition, based on the percentage each author or developer contributed to the total offering.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. Amendment filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
2. Repealer and new section filed 10–1–84; effective upon filing pursuant to Government Code section 11346.2(d) (Register 84, No. 40).
3. Repealer of subsection (b)(3) and new subsection (b)(3) filed 5–26–92; operative 6–25–92 (Register 92, No. 22).
4. Editorial correction of subsection (b)(3) (Register 95, No. 42).

§ 3011.1. Petitions for Equivalency for Course Instruction.

(a) For instruction of real estate related courses not approved for continuing education, submit a statement under penalty of perjury which includes at least the following information:

(1) The petitioner's qualifications to teach the course.

(2) The title of the course.

(3) The date and location the instruction took place.

(4) Clock hours of instruction.

(5) Titles and description of instruction materials used including the date of publication, and an outline or syllabus of the course.

(6) Any other information useful in determining that the course will contribute to current knowledge as set forth in Business and Professions Code Section 10170.4.

(7) A statement by the course sponsor or school that the petitioner taught the course.

(b) Instructors of approved continuing education courses may receive a certificate of completion for the number of hours actually spent in instruction at one presentation of the course.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27).
2. Amendment of subsections (a)(5) and (a)(7) filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
3. Amendment of subsections (a)(6) and (b) filed 7–31–98; operative 8–30–98 (Register 98, No. 31).

§ 3011.2. Petitions for Equivalency for Authorship of Articles or Books.

(a) Submit a copy of the published article or book.

(b) Submit a statement signed under penalty of perjury which includes at least:

(1) The date of publication of the article or book.

(2) An explanation of how the material published meets the criteria of Section 3011.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 7–5–84; effective thirtieth day thereafter (Register 84, No. 27).
2. Amendment of subsection (b)(1) and repealer of subsection (b)(3) filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3011.3. Petitions for Equivalency for Development of Real Estate Programs, Laws, and Research.

(a) If the claim for continuing education credit is based upon development of education programs, submit a statement under penalty of perjury including at least the following information:

(1) A clear and complete description of the education program.

(2) A description of the role of the petitioner in developing the program.

(3) The number of hours the petitioner devoted to development of the program.

(4) The period during which the program was developed.

(5) An explanation of how the development of the program meets the standard of Section 3011.

(b) If the claim involves development of real estate law or research, submit a statement under penalty of perjury that includes at least:

(1) A detailed description of the law affected or the research performed.

(2) The number of hours devoted to the research or development of law.

(3) An explanation of how the petitioner's participation meets the standard set forth in Section 3011.

(4) A copy of the research report or of the law developed shall be attached to the petition, if the report or law exists. If research support data is not available, the Commissioner may request whatever additional information is needed to support the claim.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27).

§ 3011.4. Petitions for Equivalency for Attendance at Unapproved Programs.

(a) The Commissioner, when acting upon a petition for continuing education credit for completing a course that is not approved, shall apply the criteria set forth in Sections 3006 and 3007.3.

(b) The applicant shall submit a petition under penalty of perjury including at least the following information:

(1) The name, address, and telephone number of the course sponsor or school.

(2) The title of the course.

(3) The title, publisher, and date of publication of any text or course material used.

(4) The number of clock hours attended.

(5) Any outline or syllabus.

(6) A final grade report for the final examination(s) and a list of reading assignments with page references.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 10–1–84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 40).
2. Amendment of subsection (b)(5), repealer of subsection (b)(7) and subsection renumbering filed 11–27–96; operative 12–27–96 (Register 96, No. 48).
3. Amendment of subsections (a) and (b)(6) and repealer of subsection (b)(7) filed 7–31–98; operative 8–30–98 (Register 98, No. 31).
4. Amendment of subsections (a) and (a)(6) filed 8–29–2007; operative 2–29–2008 (Register 2007, No. 35).

§ 3012. Extension Conditions.

An extension of the time for completing the continuing education requirements may be obtained by submitting with the regular renewal application evidence showing that applicant was unable to comply with the continuing education requirements. Such evidence may be (1) health reasons preventing attendance, (2) active duty in the military service with assignment to a permanent duty station outside of the state during the last 18 months of a license period, or (3) other compelling cause beyond the control of the applicant while engaged in the real estate business.

The Commissioner may extend an otherwise expired license while investigating such evidence for not to exceed 90 days if he finds applicant can reasonably be expected to be found to meet minimum requirements for renewal under this Article.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.4, Business and Professions Code.

HISTORY

1. Amendment filed 5–18–81; effective thirtieth day thereafter (Register 81, No. 21).
2. Amendment filed 7–5–84; designated effective 8–1–84 (Register 84, No. 27).
3. Amendment filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).

§ 3012.2. Record Keeping.

The sponsor shall maintain a record of attendance of each participant, for a period of five years, sufficient to allow for the preparation of a duplicate certificate upon request by a participant.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10170.4 and 10170.5, Business and Professions Code.

HISTORY

1. New section filed 10–1–84; effective upon filing pursuant to Government Code section 11346.2(d) (Register 84, No. 40).
2. Amendment of subsection (a) filed 4–2–86; effective thirtieth day thereafter (Register 86, No. 14).
3. Amendment of subsections (a) and (b) filed 5–4–89; operative 6–3–89 (Register 89, No. 23).
4. Amendment of subsection (a) filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
5. Editorial correction of printing errors (Register 91, No. 44).
6. Amendment filed 11–13–96; operative 11–13–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 46).

§ 3012.3. "Good Standing" Defined.

The term "good standing" as used in Section 10170.8 of the Code does not include any time when the license was expired.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Section 10170.8, Business and Professions Code.

HISTORY

1. New section filed 2–28–2006; operative 3–30–2006 (Register 2006, No. 9).

§ 3013. License Renewal Procedure.

In making application for renewal of a real estate license, the applicant shall provide such information as the Department may require concerning continuing education offerings that the applicant has completed within the four years immediately preceding expiration of the license or in the case of an application made pursuant to Section 10201 of the Code within the four years immediately preceding the date that the application is submitted to the Department. If requested by the Department, the applicant shall submit certificates of attendance or certified copies thereof from sponsors of approved offerings to substantiate information provided by the applicant.

NOTE: Authority cited: Sections 10080 and 10170.4, Business and Professions Code. Reference: Sections 10156.2, 10170.4, 10171 and 10171.2, Business and Professions Code.

HISTORY

1. Amendment filed 7–9–80; effective thirtieth day thereafter (Register 80, No. 28).
2. Repealer and new section filed 7–1–83; effective thirtieth day thereafter (Register 83, No. 30).
3. Amendment filed 1–11–84; effective thirtieth day thereafter (Register 84, No. 2).

Article 25.2. Minority and Women Business Participation Goals for State Contracts

§ 3050. Definitions.

NOTE: Authority cited: Section 10080, Business and Professions Code, Section 10115.3. Public Contract Code Reference: Section 10451.5, Business and Professions Code, Section 10115.1, Public Contract Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3051. Minority and Women Business Enterprise Goals.

NOTE: Authority cited: Section 10080, Business and Professions Code, Section 10115.3Public Contract Code. Reference: Sections 10115 and 10115.2, Public Contract Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3052. Good Faith Effort.

NOTE: Authority cited: Section 10080, Business and Professions Code, Section 10115.3, Public Contract Code. Reference: Sections 10115 and 10115.2, Public Contract Code

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3053. Contract Awards.

NOTE: Authority cited: Section 10080, Business and Professions Code. Section 10115.3, Public Contract Code. Reference: Section 10115.2, Public Contract Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3054. Certification.

NOTE: Authority cited: Section 10080, Business and Professions Code. Section 10115.2, Public Contract Code. Reference: Sections 10115.1 and 10115.10, Public Contract Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3055. Contract Audits.

NOTE: Authority cited: Section 10080, Business and Professions Code. Section 10115.3, Public Contract Code. Reference: Section 10115.3, Public Contract Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3056. Adjudicatory and Investigatory Procedures.

NOTE: Authority cited: Section 10080, Business and Professions Code. Section 10115.3, Public Contract Code. Reference: Sections 10115.2 and 10115.3, Public Contract Code.

HISTORY

1. New section filed 7–12–91; operative 8–11–91 (Register 91, No. 44).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

Article 26. Recovery Account

§ 3100. Definitions.

As used in this Article, the following definitions will apply:

(a) "Recovery Account" means the separate account in the Real Estate Fund established pursuant to Section 10450.6 of the Code for purposes of carrying out the provisions of Chapter 6.5 of the Real Estate Law.

(b) "Application" means an application for payment from the Recovery Account filed with the Department pursuant to Section 10471(a) of the Code.

(c) "Party" means either the claimant, the judgment debtor, or the Department.

(d) "Claimant" means an aggrieved person who filed an application pursuant to Section 10471(a) of the Code.

(e) "Person" includes corporation, partnership, company or firm.

(f) "Final Judgment" means a judgment, arbitration award, or criminal restitution order for which the period for appeal has expired, enforcement of which is not barred by the order of any court or by any statutory provision, and which has not been nullified or rendered void by any court order or statutory provision.

(g) "Court of Competent Jurisdiction" means a small claims, municipal or superior court of the State of California, or a United States district court or United States bankruptcy court sitting to conduct its affairs within the boundaries of the State of California.

(h) "County in Which a Judgment Was Rendered" means the county within California in which the court issuing the judgment or restitution order sits or, if the claim is based on an arbitration award, the county in which the arbitration was conducted, or in which the claimant resides.

(i) Where appropriate to the context the singular number includes the plural and the plural number includes the singular.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10450.6, 10470, 10470.1, 10471, 10471.1, 10471.2, 10471.3, 10471.4, 10471.5, 10471.6, 10472, 10472.1, 10473, 10473.1, 10474, 10474.5, 10475, 10476, 10477, 10478, 10479, 10480 and 10481, Business and Professions Code.

HISTORY

1. New section filed 12–15–86; designated effective 1–1–87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).
2. New subsections (g) and (h) and subsection relettering filed 12–30–97; operative 1–29–98 (Register 98, No. 1).
3. Amendment of subsections (f) and (h) filed 10–26–99; operative 11–25–99 (Register 99, No. 44).

§ 3101. Application for Payment from Recovery Account.

(a) An application for payment from the Recovery Account shall be made on a form prescribed by the Department, shall contain the items specified by Section 10471(c) of the Code, and shall contain all of the information specified in Section 3102, except as provided in subdivision (b) of this section. The application shall be verified by the claimant in the manner specified in Section 446 of the Code of Civil Procedure for the verification of a pleading. If executed outside of California, the information in the application and accompanying documents shall be verified before a person qualified to administer oaths within the jurisdiction where executed or certified under penalty of perjury in accordance with the provisions of subdivision (b) of Section 2015.5 of the Code of Civil Procedure.

(b) The claimant may submit with the application less than all of the information defined by Section 3102 of these regulations as constituting a substantially complete application if the claimant believes that the information submitted with the application is sufficient for the Department to determine whether the application qualifies under Sections 10470 through 10481 of the Code for payment from the Recovery Account. However, an application will not be deemed substantially complete within the meaning of Section 3102 of these regulations unless:

(1) The Department determines that what has been submitted is sufficient for it to make a determination whether the application qualifies for payment from the Recovery Account and so notifies the claimant as provided in Section 3105 of these regulations; or

(2) The application and supporting information meet all of the requirements specified in Section 3102 of these regulations.

(c) If any documents or other attachments are submitted with the application, the application shall contain a verification by the claimant that the documents are true and correct copies of the originals, and if such documents purport to be copies of documents filed in court that they are true and correct copies of the originals filed with the court.

(d) The application shall contain the name and address of the claimant, and if the claimant is not being represented by an attorney in the filing of the application, a telephone number where the claimant can be reached during regular business hours. If the claimant is represented by an attorney in filing of the application, the application shall contain the name, business address, and telephone number of the attorney.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Sections 10471 and 10471.2, Business and Professions Code.

HISTORY

1. New section filed 12–15–86; designated effective 1–1–87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).
2. Amendment of subsection (b) filed 11–16–87; operative 12–16–87 (Register 87, No. 47).

§ 3102. Substantially Complete Application.

Except as provided in Section 3101 of these regulations, an application for payment from the Recovery Account is "substantially complete" within the meaning of Section 10471.2(b) of the Code if it contains all of the documents and information enumerated below:

(a) Proof that the judgment debtor was served with the Notice and Application.

(b) A copy of the judgment showing it to be a final judgment as defined in this article, and any findings of facts, conclusions of law, jury verdicts, jury special verdicts, statements of decisions, memorandum decisions, or any other indication by the court or jury, as the case may be, of its decision and the reasons for the decision. If the original judgment was appealed, copies of the appellate decision and remittitur.

(c) Copies of the original complaint, answer, cross-complaints, answers to cross-complaints, and all amendments or other subsequent versions of any of those documents.

(d) Copies of any pre-trial or post-trial briefs or settlement conference statements.

(e) A listing of all depositions and interrogatories taken in the underlying action, describing the party or parties taking the deposition or propounding the interrogatories, the deponent or person responding to interrogatories, and all persons present at any deposition.

(f) Copies of any demurrers or motions for summary judgment, supporting documents, and rulings thereon.

(g) Copies of all documents reflecting the terms of the underlying transaction, including for example offers, counteroffers, escrow instructions, closing statements, deeds, notes and deeds of trust.

(h) A detailed narrative description by the claimant under penalty of perjury of all the facts of the underlying transaction, including how he or she was damaged by the judgment debtors, and the roles of all other persons involved in the transaction (such as other brokers or salespersons, sellers and buyers).

(i) A description by the claimant of the basis for each element of damages.

(j) If the only judgment debtor was a salesperson, a statement as to why the employing broker was not either sued or taken to judgment.

(k) If any codefendants were dismissed from the underlying lawsuit, a statement of the reason for dismissal as to each such codefendant.

(*l*) A list of the names of any witnesses who testified at the underlying trial and the present or last known addresses of the witnesses to the extent known by the claimant.

(m) A description of searches and inquiries conducted by or on behalf of the claimant with respect to the assets of the judgment debtor and the assets of all other persons liable to the claimant in the transaction which assets may be liable to be sold or applied to the losses suffered by the claimants, an itemized valuation of the assets discovered, and the results of actions by the claimant to have the assets applied to the losses suffered by the claimant.

(n) If the claimant claimed any loss related to the transaction as a deduction on his or her tax return or returns, a description of the amount of the tax benefit derived therefrom.

(o) A statement whether the judgment debtor is known to have filed bankruptcy. If so, a statement whether the claimant was named as a creditor in the bankruptcy, filed a claim in the bankruptcy, and pursued an adversary complaint to have the debt determined to be nondischargeable. If the judgment debtor filed bankruptcy and the claimant failed to take any of the foregoing actions, a statement as to why the claimant failed to take such actions.

(p) Abstracts of judgment bearing evidence of having been recorded in the county or counties in which the judgment debtor may possibly have assets.

(q) If any of the above items are not included in the initial application, or are requested in a deficiency letter and not supplied, a statement under penalty of perjury that the claimant has made a diligent effort to locate and produce the items but has been unable to locate them or has found that they do not exist.

(r) All documents or copies of documents submitted to meet the requirements of this section must be clear and legible.

(s) Certification by the claimant that all documents submitted are true and correct copies of the originals, and if such documents purport to be copies of documents filed in court, that they are true and correct copies of the originals filed with the court.

NOTE: Authority cited: Sections 10080 and 10471.2, Business and Professions Code. Reference: Section 10471.2, Business and Professions Code.

HISTORY

1. New section filed 12-15-86; designated effective 1-1-87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).
2. Amendment of subsection (a) filed 3-18-88; operative 4-17-88 (Register 88, No. 14).

§ 3103. Response by Judgment Debtor.

(a) The response by a judgment debtor must contain a verification that a copy of the response was sent to the claimant, or if the claimant is represented by an attorney, to the claimant's attorney, at the address specified in the application for the claimant or his or her attorney.

(b) If the judgment debtor is not represented by an attorney in objecting to payment of the application, the response must contain the judgment debtor's name, the address at which he or she wishes to receive correspondence and notices relating to the application, and a telephone number where he or she can be reached during regular business hours. If the judgment debtor is represented by an attorney in objecting to the application, the response must contain the name, business address, and telephone number of the attorney.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10471.1, Business and Professions Code.

HISTORY

1. New section filed 12-15-86; designated effective 1-1-87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).
2. Repealer of subsection (a), subsection relettering, and amendment of newly designated subsection (a) filed 11-27-96; operative 12-27-96 (Register 96, No. 48).

§ 3104. Subsequent Service of Correspondence and Notices.

After initial service of the application on the Department and the judgment debtor by the claimant as provided by sections 10471(b) and 10471.1(a) and (b), and after service of a response by the judgment debtor as provided by section 10471.1(c) of the Code and section 3103 of these regulations, all parties shall be served with subsequent correspondence and notices by first class mail as follows:

(a) The Department shall be served at:
Department of Real Estate
Recovery Account Unit
P.O. Box 187007
Sacramento, CA 95818-7007

(b) The claimant shall be served at his or her address as specified in the application, or if the claimant is represented by an attorney, at the address of the attorney as specified in the application.

(c) The judgment debtor shall be served at his or her address as specified in the response, or if the judgment debtor is represented by an attorney as specified in the response.

If the claimant or judgment debtor later wishes to be served at an address other than as specified above, such party shall notify the other parties by first class mail of the new address.

NOTE: Authority cited: Section 10080, Business and Professions Code Reference: Sections 10471, 10471.1, 10471.2, 10471.5 and 10472, Business and Professions Code.

HISTORY

1. New section filed 12-15-86; designated effective 1-1-87 pursuant to Government Code section 11346.2(d) (Register 86, No. 51).
2. Amendment of subsection (a) filed 3-18-88; operative 4-17-88 (Register 88, No. 14).
3. Amendment of subsection (a) filed 7-12-91; operative 8-11-91 (Register 91, No. 44).

§ 3105. Notification of Substantially Complete Application.

NOTE: Authority cited: Sections 10080 and 10471.2, Business and Professions Code. Reference: Sections 10471.2 and 10471.3, Business and Professions Code.

HISTORY

1. New section filed 12-15-86; designated effective 1-1-87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).

2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3106. Procedures to Be Followed When Judgment Debtor Has Filed a Response.

(a) A judgment debtor who has filed a response objecting to payment to a claimant from the Recovery Account may submit written argument setting forth in detail the factual and legal bases upon which he or she believes the application should be denied. Such argument may be submitted at any time from the filing of the response until 30 days after the date of mailing of the Notice set forth in Section 10471.1(c) of the Code, and shall be served upon the Department and the claimant as specified in Section 3104 of these regulations.

(b) The claimant shall have 30 days after the mailing of argument by the judgment debtor in which to submit his or her own argument in favor of payment. Such argument by the claimant shall be served upon the Department and the judgment debtor as provided in Section 3104 of these regulations.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10471.1, Business and Professions Code.

HISTORY

1. New section filed 12–15–86; designated effective 1–1–87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).
2. Amendment of subsection (a) filed 11–9–2000; operative 12–9–2000 (Register 2000, No. 45).

§ 3107. Unreasonable Delay by Claimant in Responding to Deficiency Letter.

(a) In the event that the Department has mailed one or more itemized lists of deficiencies to a claimant as provided by Section 10471.2(a) of the Code, and if after an unreasonable length of time the Department has received no response to the latest such list of deficiencies, the Department may notify the claimant that unless the application is substantially complete within a specified period of time of not less than 30 days, the application will be denied.

(b) The determination of what constitutes an unreasonable length of time shall be within the discretion of the Commissioner, taking into account the degree of difficulty in meeting the deficiencies specified. However, an "unreasonable length of time" shall not be deemed to be less than six months after the last mailing of a list of deficiencies.

(c) If no response has been received from the claimant after the passing of the deadline specified by the Department pursuant to subdivision (a) of this section, the Commissioner may deny the application.

NOTE: Authority cited: Sections 10080 and 10471.2, Business and Professions Code. Reference: Sections 10471.2, 10471.3, Business and Professions Code.

HISTORY

1. New section filed 12–15–86; designated effective 1–1–87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).

§ 3108. Procedure upon Filing of Proration Proceeding.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10471.6, Business and Professions Code.

HISTORY

1. New section filed 12–15–86; designated effective 1–1–87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).
2. Repealer filed 11–27–96; operative 12–27–96 (Register 96, No. 48).

§ 3109. Procedure upon Filing of Writ of Mandamus by Judgment Debtor.

(a) If the decision of the Commissioner is to make a payment out of the Recovery Account, and the judgment debtor files a writ of mandamus as provided in Section 10471.5(c) of the Code, no payment shall be made of the pending application unless and until the writ of mandamus has been denied and such denial has become final.

(b) If such writ of mandamus is granted on the basis that the claimant has not met the requirements for payment from the Recovery Account, the application shall be denied.

NOTE: Authority cited: Section 10080, Business and Professions Code. Reference: Section 10471.5, Business and Professions Code.

HISTORY

1. New section filed 12–15–86; designated effective 1–1–87 pursuant to Government Code Section 11346.2(d) (Register 86, No. 51).

Article 36. Conflict of Interest Code of the Department of Real Estate

NOTE: Pursuant to a regulation of the Fair Political Practices Commission (Title 2, CCR, section 18750(k)(2)), an agency adopting a conflict of interest code has the options of requesting that the code either be (1) printed in the CCR in its entirety or (2) incorporated by reference into the CCR. Here, the adopting agency has requested incorporation by reference. However, the full text of the regulations is available to the public for review or purchase at cost at the following locations:

DEPARTMENT OF REAL ESTATE
2201 BROADWAY
P.O. BOX 187000
SACRAMENTO, CA 95818–7000

FAIR POLITICAL PRACTICES COMMISSION
428 J STREET
SACRAMENTO, CA 95814–2331

ARCHIVES
SECRETARY OF STATE
1020 O STREET
SACRAMENTO, CA 95814–5704

The Conflict of Interest Code is designated as Article 36, Chapter 6 of Title 10 of the California Code of Regulations, and consists of sections numbered and titled as follows:

Article 36. Conflict of Interest Code of the Department of Real Estate

Section
3200. General Provisions
Appendix

NOTE: Authority cited: Sections 87300 and 87304, Government Code. Reference: Sections 87300, 87302, 87306, 89503, and 89505, Government Code.

HISTORY

1. New Article 36 (sections 3200–3208) filed 5–20–77; effective thirtieth day thereafter. Approved by Fair Political Practices Commission 3–17–77 (Register 77, No. 21).
2. Amendment of section 3201 filed 12–3–80; effective thirtieth day thereafter (Register 80, No. 49).
3. Repealer of article 36 (sections 3200–3208) and new article 36 (section 3200 and Appendix) filed 2–26–81; effective thirtieth day thereafter. Approved by Fair Political Practices Commission 12–1–80 (Register 81, No. 9).
4. Amendment filed 12–12–91; operative 1–13–92. Approved by Fair Political Practices Commission 10–9–91 (Register 92, No. 10).
5. Editorial correction of HISTORY 4 (Register 95, No. 42).
6. Amendment of addresses, section and appendix filed 9–17–97; operative 10–17–97. Approved by Fair Political Practices Commission 7–31–97 (Register 97, No. 38).
7. Amendment of Appendix filed 2–13–2003; operative 3–15–2003. Approved by Fair Political Practices Commission 12–5–2002 (Register 2003, No. 7).

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Title 10. Investment

Chapter 6.5. Real Estate Appraisers

Vol. 14

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Chapter 6.5. Real Estate Appraisers

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Chapter 6.5. Real Estate Appraisers

Article 1. Definitions

§ 3500. Meaning of Words and General Definitions.

(a) Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. Words used in their present tense include the future tense and words in the singular form include the plural form. Use of the word "shall" or "must" denotes mandatory conduct; "may" denotes permissive conduct; and "should" denotes recommended conduct.

(b) As used in these regulations, the following words and phrases shall have the following definitions:

(1) "Applicant" means a natural person who has made application to be a State Licensed Real Estate Appraiser, a State Certified Real Estate Appraiser, a Course Provider or a person who has applied for a Trainee License, a Reciprocal License or a Temporary Practice Permit;

(2) "Appraisal Standards Board (ASB)" means the board of The Appraisal Foundation;

(3) "Appraisal Subcommittee (ASC)" means the Appraisal Subcommittee of the Federal Financial Institutions Examination Council;

(4) "Appraiser" means an individual who holds a license issued by the Office of Real Estate Appraisers;

(5) "Appraiser Qualifications Board (AQB)" means the subcommittee of The Appraisal Foundation. The "Appraiser Qualifications Board" (AQB) is the board of The Appraisal Foundation which promulgates the minimum national requirements for licensure for licensed appraisers. The minimum national requirements includes the interpretations and clarification's of the appraiser qualifications criteria issued by AQB;

(6) "Course Provider" means a person or organization that has been approved by the Office of Real Estate Appraisers to provide educational courses within the parameters set forth herein.

(7) "Director" means the Director of OREA or his or her designee;

(8) "FIRREA" means the Financial Institutions Reform, Recovery and Enforcement Act of 1989, Public Law 101–73 and any amendments thereto;

(9) "Non–residential property" means all other property except one to four unit residential structures and land suitable for one to four unit residential use;

(10) "Office" means the Office of Real Estate Appraisers, and/or the Director;

(11) "OREA" means the Office of Real Estate Appraisers;

(12) "Residential property" means real property containing, and land suitable for, four or fewer residential units.

(13) "Uniform Standards of Professional Appraisal Practice; (USPAP)" means those standards as adopted by the Appraisal Standards Board of the Appraisal Foundation.

NOTE: Authority cited: Sections 11310, 11313, 11314, 11316, 11350 and 11361, Business and Professions Code. Reference: Sections 10, 11302, 11310, 11360 and 11361, Business and Professions Code.

HISTORY

1. New chapter 6.5, article 1 and section filed 6–7–94; operative 6–7–94 (Register 94, No. 23). For prior history, see Register 93, No. 8.
2. Amendment of section and NOTE filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).
3. Amendment of subsection (b)(1), new subsection (b)(6), subsection renumbering and amendment of NOTE filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

Article 2. General Requirements

§ 3501. Business Entities.

NOTE: Authority cited: Sections 11313, 11314 and 11325, Business and Professions Code. Reference: Sections 11320 and 11325, Business and Professions Code.

HISTORY

1. New article 2 and section filed 6–7–94; operative 6–7–94 (Register 94, No. 23).
2. Repealer filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3521. Scope of Practice.

The types of federally related transactions which shall be performed by each class of licensed appraisers shall be as provided in Section 323.3 of Part 323 of Subchapter B of Chapter III of Title 12 of the Code of Federal Regulations.

NOTE: Authority cited: Section 11325, Business and Professions Code. Reference: 12 C.F.R., Part 323, Section 323.3.

HISTORY

1. Renumbering and amendment of former section 3503 to new section 3521 and renumbering of former section 3521 to new section 3566 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3522. License.

Each license shall show on its face in clear and concise language the following information:

(a) The name of the holder;

(b) The license number;

(c) The scope of authority conferred by the document;

(d) Whether restricted or limited in any manner, and if so, the nature of the restriction or limitation; and

(e) The dates of issuance and expiration of the document.

NOTE: Authority cited: Section 11314, Business and Professions Code. Reference: Sections 11320 and 11321, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3504 to new section 3522, and renumbering of former section 3522 to new section 3567 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3523. License Property of the Office.

Each license shall remain the property of the Office and shall be surrendered to the Office or its authorized representative upon order of the Director, unless otherwise ordered pursuant to these regulations.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Sections 11315 and 11319, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3523 to new section 3568 and new section filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3524. Term of License.

Every original license shall be valid for the term set forth in Section 11341 of the Business and Professions Code unless otherwise ordered pursuant to these regulations.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Section 11341, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3505 to new section 3524 and renumbering of former section 3524 to new section 3569 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3525. Temporary Practice Permit.

(a) In lieu of obtaining a license, appraisers with currently valid unrestricted licenses issued by another state may be issued a Temporary Practice Permit to perform a single appraisal assignment.

(b) A Temporary Practice Permit is not required if an appraiser from another state associates with an appraiser licensed in California and the work is limited to assisting in the preparation of an appraisal under the conditions specified in Business and Professions Code Section 11324.

(c) The applicant shall have satisfied the requirements for a license in a state or territory where the licensing provisions comply with Title XI of FIRREA and where the Appraisal Subcommittee has not issued a finding that the policies, practices, or procedures of the state or territory are inconsistent with Title XI.

(d) The license held shall be current and in good standing with the issuing state or territory.

(e) A Temporary Practice Permit is required when any appraiser enters California to appraise or provide technical review services in a federally related transaction and the appraiser is not licensed in California.

(f) Application for a Temporary Practice Permit shall be made on Request for Temporary Practice Permit Form REA 3009 (Rev. 5/8/00) which is herein incorporated by reference, or any federally–approved equivalent form to the Office at its principal office in Sacramento, together with the fees specified in Section 3582 and such information as may be requested by the Director.

(g) An appraisal assignment under such temporary practice shall be completed within one year after issuance of the Temporary Practice Permit, or within the period of time that the applicant holds a valid, current license in his or her issuing state whichever is sooner. The term of the Temporary Practice Permit shall not be extended.

NOTE: Authority cited: Sections 11313, 11314, 11324, 11340, 11350 and 11352, Business and Professions Code. Reference: Sections 11350 and 11351, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3507 to new section 3525 and renumbering of former section 3525 to new section 3570 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsection (f) filed 11–2–99; operative 12–2–99 (Register 99, No. 45).
3. Change without regulatory effect amending subsection (f) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
4. Amendment of subsections (a) and (g) and amendment of NOTE filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

§ 3526. Consent to Service of Process.

Each applicant for a license or temporary practice permit who is a non–resident of California shall complete the Consent to Service of Process REA Form 3006 (Rev. 5/8/00), which is herein incorporated by reference or any federally–approved equivalent form.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 1018, Code of Civil Procedure.

HISTORY

1. Renumbering and amendment of former section 3508 to new section 3526 and renumbering of former section 3526 to new section 3581 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment filed 11–2–99; operative 12–2–99 (Register 99, No. 45).
3. Change without regulatory effect amending section filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3527. Personal Information or Contact Change.

(a) All applicants for and holders of a license, temporary practice permit, or course provider approval shall submit written notice to OREA of any change to the following within 10 days on the Change Notification and Miscellaneous Requests REA Form 3011 (Rev. 5/8/00):

(1) Name;

(2) Residence telephone number;

(3) Business telephone number;

(4) Residence address;

(5) Business name or address; or

(6) Mailing address.

(b) The business name, address and telephone number shall be considered the applicant or licensee's address and telephone number of record for all purposes unless otherwise requested in writing by the applicant or licensee and shall be considered a matter of public record. If no business address is provided, the mailing address shall be the address of record.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3509 to new section 3527 and renumbering of former section 3527 to new section 3582 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (a) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
3. Amendment of subsection (a) filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

§ 3528. Minimum Requirements.

All applicants for, and holders of, any license or permit authorized by this chapter shall meet the minimum requirements set forth in this chapter or those established by the Appraiser Qualifications Board, whichever is greater.

Effective January 1, 2008, all applicants for licensure must meet all of the minimum requirements effective on that date. Applications received on or before December 31, 2007, that are not complete as to education and/or experience, will be evaluated based on the completion date of the education and/or experience component requirements. Applicants who have completed the education requirements prior to January 1, 2008, may complete the experience requirement after January 1, 2008.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Sections 11328 and 11340, Business and Professions Code; and Section 1112, Financial Institutions Reform, Recovery and Enforcement Act of 1989, Public Law 101–73 (FIRREA).

HISTORY

1. Renumbering and amendment of former section 3528 to new section 3601 and new section filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of section and NOTE filed 6–5–2006 as an emergency; operative 6–5–2006 (Register 2006, No. 23). A Certificate of Compliance must be transmitted to OAL by 10–3–2006 or emergency language will be repealed by operation of law on the following day.
3. Amendment filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).
4. Amendment of section and NOTE refiled 9–14–2006 as an emergency; operative 10–4–2006 (Register 2006, No. 37). A Certificate of Compliance must be transmitted to OAL by 2–1–2007 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 9–14–2006 order transmitted to OAL 12–7–2006 and filed 1–10–2007 (Register 2007, No. 2).

§ 3529. Audits.

The Office may conduct audits of applicant's, licensee's and educational provider records to determine compliance with the requirements of this chapter and state and federal law. Applicants, licensees and educational providers shall cooperate with the Office in the conduct of such audits and provide access during normal business hours to records and such information as the Office deems reasonably necessary for the completion of the audit.

NOTE: Authority cited: Sections 11313, 11314, 11328 and 11340, Business and Professions Code. Reference: Sections 11328 and 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3529 to new section 3602 and new section filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3530. Limitations on Licenses for Aliens.

(a) All eligibility requirements contained herein shall be applied without regard to the race, creed, color, gender, religion, national origin, or disability of the individual applying for the public benefit.

(b) Pursuant to Section 411 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. No. 104–193) (PRWORA)), (8 U.S.C. § 1621), and notwithstanding any other provision of this division, aliens who are not qualified aliens, nonimmigrant aliens under the Immigration and Nationality Act (INA) (8 U.S.C. § 1101 et seq.), or aliens paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)) for less than one year, are not eligible to receive any license to act as a state licensed real estate appraiser as set forth in California Business and Professions Code, Division 4, Part 3, Sections 11300 et seq., except as provided in 8 U.S.C. § 1621(c)(2).

(c) A qualified alien is an alien who, at the time he or she applies for, receives, or attempts to receive a public benefit, is under Section 431(b) and (c) of the PRWORA (8 U.S.C. § 1641(b) and (c)), any of the following:

(1) An alien who is lawfully admitted for permanent residence under the INA (8 U.S.C. § 1101 et seq.).

(2) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. § 1158).

(3) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. § 1157).

(4) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)) for a period of at least one year.

(5) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. § 1253(h)) (as in effect immediately before the effective date of Section 307 of Division C of Public Law 104–208) or Section 241(b)(3) of such Act (8 U.S.C. § 1251(b)(3)) (as amended by Section 305(a) of Division C of Public Law 104–208).

(6) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980. (8 U.S.C. § 1153(a)(7)) (See editorial note under 8 U.S.C. § 1101, "Effective Date of 1980 Amendment.")

(7) An alien who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (8 U.S.C. § 1522 note)).

(8) An alien who meets all of the conditions of subparagraphs (A), (B), (C), and (D) below:

(A) The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Office. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien from the abuser.

3. The benefits are needed due to loss of financial support resulting from the alien's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien to lose his or her job or to earn less or to require the alien to leave his or her job for safety reasons.

5. The benefits are needed because the alien requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

(C) The alien has a petition that has been approved or has a petition pending which sets forth a prima facie case for:

1. status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. § 1154(a)(1)(A)(ii), (iii) or (iv)),

2. classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. § 1154(a)(1)(B)(ii) or (iii)),

3. suspension of deportation and adjustment of status pursuant to section 244(a)(3) of the INA (8 U.S.C. sec. 1254) as in effect prior to April 1, 1997 [Pub.L. 104–208, sec. 501 (effective Sept. 30, 1996, pursuant to sec. 591); Pub.L. 104–208, sec. 304 (effective April 1, 1997, pursuant to sec. 309); Pub.L. 105–33, sec. 5581 (effective pursuant to sec. 5582)] (incorrectly codified as "cancellation of removal under section 240A of such Act [8 U.S.C. § 1229b] (as in effect prior to April 1, 1997),"

4. status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. § 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 U.S.C. § 1154(a)(1)(B)(i)), or

5. cancellation of removal pursuant to Section 240A(b)(2) of the INA (8 U.S.C. § 1229b(b)(2)).

(D) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(9) An alien who meets all of the conditions of subparagraphs (A), (B), (C), (D) and (E) below:

(A) The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) The alien did not actively participate in such battery or cruelty.

(C) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Office. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien's child to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien's child from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's child's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien's child to lose his or her job or to earn less or to require the alien's child to leave his or her job for safety reasons.

5. The benefits are needed because the alien's child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's child's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien's child and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien's child had when living with the abuser.

(D) The alien meets the requirements of subsection (c)(8)(C) above.

(E) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(10) An alien child who meets all of the conditions of subparagraphs (A), (B), and (C) below:

(A) The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Office. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien child's parent to become self-sufficient following the separation from the abuser.

2. The benefits are needed to enable the alien child's parent to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien child's parent from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien child's parent's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien child's parent to lose his or her job or to earn less or to require the alien child's parent to leave his or her job for safety reasons.

5. The benefits are needed because the alien child's parent requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are is needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien child's parent's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into a day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien child's parent and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien child's parent had when living with the abuser.

(C) The alien child meets the requirements of subsection (c)(8)(C) above.

(d) For purposes of this section, "nonimmigrant" is defined the same as in Section 101(a)(15) of the INA (8 U.S.C. § 1101(a)(15)).

(e) For purposes of establishing eligibility for any license to act as a state licensed real estate appraiser, California Business and Professions Code, Division 4, Part 3, Sections 11300 et seq., all of the following must be met:

(1) The applicant must declare himself or herself to be a citizen of the United States, a qualified alien under subsection (c), a nonimmigrant alien under subsection (d), or an alien paroled into the United States for less than one year under Section 212(d)(5) of the INA (8 U.S.C. § 1182(d)(5)). The applicant shall declare that status through use of the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits," Form REA 3030 (Rev. 5/8/00), which is herein incorporated by reference.

(2) The applicant must present documents of a type acceptable to the Immigration and Naturalization Service (INS) which serve as reasonable evidence of the applicant's declared status. A fee receipt from the INS for replacement of a lost, stolen, or unreadable INS document is reasonable evidence of the alien's declared status.

(3) The applicant must complete and sign Form REA 3030 (Rev. 5/8/00).

(4) Where the documents presented do not on their face reasonably appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the documents shall be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The Office shall request verification from the INS by filing INS Form G-845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant shall be referred to the local INS office to obtain documentation.

(5) The type of documentation referred to the INS for verification pursuant to INS Form G-845 shall include the following:

(A) The document presented indicates immigration status but does not include an alien registration or alien admission number.

(B) The document is suspected to be counterfeit or to have been altered.

(C) The document includes an alien registration number in the A60 000 000 (not yet issued) or A80 000 000 (illegal border crossing) series.

(D) The document is one of the following: an INS Form I-181b notification letter issued in connection with an INS Form I-181 Memorandum of Creation of Record of Permanent Residence, an Arrival-Departure Record (INS Form I-94) or a foreign passport stamped "PROCESSED FOR I-551, TEMPORARY EVIDENCE OF LAWFUL PERMANENT RESIDENCE" that INS issued more than one year before the date of application for any license to act as a state licensed real estate appraiser.

(6) If the INS advises that the applicant has citizenship status or immigration status which makes him or her a qualified alien, a nonimmigrant or alien paroled for less than one year under section 212(d)(5) of the INA, the INS verification shall be accepted. If the INS advises that it cannot verify that the applicant has citizenship status or an immigration status that makes him or her a qualified alien, a nonimmigrant or an alien paroled for less than one year under section 212(d)(5) of the INA, benefits shall be denied and the applicant notified pursuant to the Office's regular procedures of his or her rights to appeal the denial of benefits.

(f) Pursuant to Section 434 of the PRWORA (8 U.S.C. § 1644), where the Office reasonably believes that an alien is unlawfully in the State based on the failure of the alien to provide reasonable evidence of the alien's declared status, after an opportunity to do so, said alien shall be reported to the Immigration and Naturalization Service.

(g) Provided that the alien has completed and signed Form REA 3030 (Rev. 5/8/00) under penalty of perjury, eligibility for any license to act as a state licensed real estate appraiser shall not be delayed, denied, reduced or terminated while the status of the alien is verified.

(h) Pursuant to Section 432(d) of the PRWORA (8 U.S.C. § 1642(d)), a nonprofit charitable organization that provides federal, state or local public benefits shall not be required to determine, verify, or otherwise require proof of eligibility of any applicant or beneficiary with respect to his or her immigration status or alienage.

(i) Any applicant who is determined to be ineligible pursuant to subsection (b) and (e) or who was made eligible for any license to act as a state licensed real estate appraiser whose services are terminated, suspended, or reduced pursuant to subsections (b) and (e), is entitled to a hearing, pursuant to Chpter 5 (commencing with Section 11500) of Part

1 of Division 3 of Title 2 of the Government Code (the Administrative Procedure Act).

NOTE: Authority cited: Sections 11313, 11314, 11327, 11340, 11350 and 11352, Business and Professions Code. Reference: Sections 11320 and 11321, Business and Professions Code; and 8 U.S.C. §§ 1621, 1641 and 1642.

HISTORY

1. New section filed 8–17–98 as an emergency; operative 8–17–98 (Register 98, No. 34). A Certificate of Compliance must be transmitted to OAL by 12–15–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of subsection (e)(6) (Register 98, No. 52).
3. Certificate of Compliance as to 8–17–98 order, including amendment of subsection (a), transmitted to OAL 11–5–98 and filed 12–21–98 (Register 98, No. 52).
4. Change without regulatory effect amending subsections (e)(1), (e)(3) and (g) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

Article 3. Experience and Education Requirements

§ 3541. Minimum Experience Requirements.

(a) To meet the minimum experience requirements, applicants for certified general shall have a minimum of 3,000 hours of real property appraisal experience obtained continuously over a period of not less than 30 months in one or more of the categories listed in Section 3542. Of the 3,000 hours, certified general applicants must have a minimum 1,500 hours of non–residential appraisal experience in one or more of the categories listed in Section 3542.

(b) To meet the minimum experience requirements, applicants for certified residential shall have a minimum of 2,500 hours of real property appraisal experience obtained continuously over a period of not less than 30 months in one or more of the categories listed in Section 3542.

(c) To meet the minimum experience requirements, applicants applying to be a state licensed real estate appraiser shall have 2,000 hours of real estate appraisal experience obtained over a period of not less than 12 months in one or more of the categories listed in Section 3542.

(d) To meet the minimum experience requirements, real estate brokers applying to be a residential licensed real estate appraiser shall have a valid California real estate brokers license and 1,000 hours of real estate appraisal experience in one or more of the categories listed in Section 3542.

(e) A maximum of 400 hours of experience in review of appraisals may be credited towards the minimum experience hours, no more than 50% of which may consist of desk reviews. Only those reviews performed after obtaining 1,600 hours of acceptable experience in other categories may be credited towards meeting minimum experience requirements.

(f) All experience claimed must be in conformance with USPAP and completed after January 30, 1989.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3510 to new section 3541 and renumbering of former section 3541 to new section 3681 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. New section filed 11–1–96; operative 1–1–98 (Register 96, No. 44).
3. Editorial correction of italicized heading and HISTORY 1 (Register 96, No. 48).
4. Amendment of subsection (c), repealer of subsection (e), subsection relettering and new subsection (f) filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).
5. Deletion of text that expired by operation of law December 31, 1997 and consolidation and renumbering of histories (Register 2006, No. 32).

§ 3542. Acceptable Categories of Experience and Criteria for Each Category.

(a) Acceptable categories of experience to meet the minimum requirements of Section 3541 and the criteria for each category are as follows:

(1) Fee and staff appraisal (a real property appraisal prepared by a person who is employed by another, usually a lending institution or government agency, or who is paid a fee for the appraisal assignments he or she performs):

(A) Shall be a written document;

(B) Shall have used the entire appraisal process;

(C) Shall have used all appraisal methods (market, cost, income) customarily used for a particular property type (i.e., residential, commercial, industrial, etc.);

(D) Shall conform to USPAP, particularly Standards Rules 1 and 2; and

(E) Analysis must be completed by the applicant.

(2) Ad valorem tax appraisal (a real estate appraisal prepared by an appraiser which estimates a value that is used for property tax purposes):

(A) Appraisal:

(1) Shall be a written document;

(2) Shall use techniques to value properties similar to those used by appraisers;

(3) Shall effectively use the appraisal process; and

(4) Shall conform to USPAP, particularly Standards Rules 1 and 2.

(B) Mass Appraisal:

(1) Shall use highest and best use analysis;

(2) Shall use model specification (developing the model);

(3) Shall use model calibration (developing adjustments to the model);

(4) Components of the mass appraisal process other than (1), (2) and (3), by themselves, shall not be granted experience credit; and

(5) Shall conform to USPAP, particularly Standard Rule 6.

(3) Review of an appraisal (field or desk):

(A) Shall be a written document separate from the appraisal itself;

(B) The review shall be of an appraisal prepared either by employees, associates or others;

(C) The appraisal being reviewed shall not be signed by the reviewer;

(D) Shall be a "technical review" where the review appraiser forms an opinion as to whether the analyses, opinions, and conclusions in the appraisal report under review are appropriate and reasonable, as opposed to an "administrative review", which is work performed by clients and users of appraisal services as a due diligence function in the context of making a business decision (e.g., underwriting, buying, selling, etc.); and

(E) The work shall conform to USPAP, particularly Standard Rule 3.

(4) Appraisal analysis:

(A) Shall be a written document; and

(B) The work shall conform to USPAP, particularly Standards Rules 4 and 5.

(5) Real Estate consulting:

(A) Shall be a written document;

(B) The work shall conform to USPAP, particularly Standards Rules 4 and 5; and

(C) "Real estate consulting" incorporates those activities described in USPAP Standards Rules 4 and 5.

(6) Highest and best use analysis:

(A) Shall be a written document; and

(B) The work shall conform to USPAP, particularly Standards Rules 4 and 5.

(7) Feasibility analysis/study:

(A) Shall be a written document; and

(B) The work shall conform to USPAP, particularly Standards Rules 4 and 5.

(8) Teaching of appraisal courses:

Teaching of appraisal courses shall not be an acceptable category of experience to meet minimum requirements after December 31, 1997.

(9) Setting forth opinions of value of real property for tax purposes:

(A) Shall be experience as an employee of a California County Assessor's Office or the California Board of Equalization in setting forth opinions of value of real property for tax purposes.

(10) Assisting in the preparation of appraisals:

(A) Shall be a written document;

(B) Shall effectively use the appraisal process performing market research, data analysis and applying the appropriate appraisal techniques. The work experience must go beyond such tasks as taking photographs, typing the appraisal report, measuring improvements, or finding sales

that may or may not be used in the appraisal. At least 75% of the professional work shall have been performed by the applicant;

(C) The work shall conform to all of the applicable USPAP standards, state laws and Office of Real Estate Appraisers (OREA) regulations; and

(D) A maximum of 400 hours of assisting in the preparation of appraisals may be accepted for credit towards meeting the minimum experience requirements.

(11) Real estate valuation experience such as that of a real estate lending officer or a real estate broker:

(A) Appraisal: Same requirements as Category 1;

(B) Review of Appraisals: Same requirements as Category 3; and

(C) Consulting:

(1) Shall be a written document; and

(2) The work shall conform to USPAP, particularly Standards Rules 4 and 5.

(b) Only appraisals performed for a business purpose (e.g. loans, litigation, etc.) may be credited for purposes of meeting the minimum experience requirements except that experience gained through case studies and practicum courses that are approved by the AQB Course Approval Program may be credited for no more than 50 percent of the total experience requirement.

(c) Each applicant shall meet additional requirements as may be established from time to time by the Appraiser Qualifications Board of The Appraisal Foundation.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3511 to new section 3542 and renumbering of former section 3542 to new section 3682 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsections (a)(5) and (a)(5)(C), repealer of subsections (a)(8)(A)–(B) and subsection (a)(8)(C) designator and amendment of subsection (b) filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

§ 3543. Minimum Basic and Continuing Education Requirements.

(a) Minimum basic and continuing requirements shall be as follows:

(1) All courses shall meet the minimum AQB requirements;

(2) Basic Real Estate Appraisal and Advanced Real Estate Appraisal courses given by real estate schools which have been approved by the California Department of Real Estate as part of the requirement for a brokers license are exempt from the accreditation requirements in (3) through (5) below;

(3) All classroom attended courses shall be taken through schools that are accredited by either:

(A) the Office; or

(B) any regional accrediting agency approved by the U.S. Department of Education;

(4) Correspondence, video or remote television courses are acceptable at the trainee and residential license levels if they have been accredited pursuant to (a)(3) above;

(5) Distance education courses are acceptable at the certified level if they were:

(A) Taken at a school which has been accredited by any regional accrediting agency approved by the U.S. Department of Education, or,

(B) Reviewed and approved by the Office and the International Distance Education Certification Center (IDECC) or approved through the AQB Course Approval Program.

(6) To receive consideration for education credit for courses not accredited by (3) through (5) above, the applicant may submit a Petition for Equivalency Credit, Form REA 3005 (Rev. 5/8/00), incorporated herein by reference, pursuant to Section 3567.

(b) In addition to (a) above, continuing education requirements shall be as follows:

(1) Continuing education requirements shall be completed after the date on which the previous license was issued;

(2) Appraisers applying for renewal of a license shall average at least 10 hours of accredited continuing education per year over the term of the license for the period up to and including December 31, 1997, and an average of at least 14 hours of accredited continuing education per year over the term of the license for the period occurring on or after January 1, 1998; and

(3) Of the required hours, a minimum of 7 hours of USPAP consisting of the 7–hour National USPAP Update Course must be completed every 2 years. For licenses expiring after January 1, 2004, applicants for renewal must provide documentation of completion of the seven–hour National USPAP Update Course with each renewal application. Applicants may certify that they have read and understand all applicable California and federal laws and regulations pertaining to the licensing and certification of real estate appraisers in lieu of being required to take a minimum of four hours of federal and California appraisal–related statutory and regulatory law every four years.

(c) In addition to (a) above, basic education requirements shall be as follows:

(1) Correspondence, video, CD ROM, online, or remote television courses taken for basic education must consist of at least five lesson assignments of 3 hours each to be equivalent to a 15 hour class.

(d) The Office may accept a state real estate appraiser license in good standing issued by another state or territory of the United States as satisfactory evidence of fulfillment of the minimum educational requirements of this part, provided that the state of issuance complies with the minimum standards established by the AQB.

NOTE: Authority cited: Sections 11313, 11314, 11340 and 11361, Business and Professions Code. Reference: Public Law 101–73 (FIRREA); and Sections 11340 and 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3512 to new section 3543 and renumbering of former section 3543 to new section 3701 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsection (b)(3) filed 6–15–2000; operative 7–15–2000 (Register 2000, No. 24).
3. Change without regulatory effect amending subsection (a)(6) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
4. Amendment of subsections (a)(5), (a)(5)(B), (b)(3) and (c)(1) filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

§ 3544. Credit for Teaching Appraisal Courses.

(a) Instructors of appraisal courses may receive credit for up to one–half of either the basic education requirement or the continuing education requirement, but not both. Teaching of appraisal courses shall not be acceptable to meet minimum experience requirements after December 31, 1997.

(b) Instructors must submit written verification of their instructor experience, which shall include:

(1) Name of School;

(2) Name of Appraisal Course;

(3) Dates each course was taught;

(4) Number of hours each course was taught;

(5) Description of course content for each course taught;

(6) Certification by school official verifying the information; and

(7) Applicant's signed certification under penalty of Perjury.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3515 to new section 3544 and renumbering of former section 3544 to new section 3702 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

Article 4. Application Process

§ 3561. Application for Licensing.

(a) Applications for licensing shall be valid for one year from date of receipt by the Office, during which time the applicant must qualify for admission to the examination. The one year period shall not be extended. If the applicant wishes to be considered for licensure after expiration of the one year period, he or she must reapply, including submission of all necessary documents and payment of all applicable fees in accordance with then existing requirements.

(b) Applicants for licensing shall have an appropriate knowledge of the English language, including reading, writing and spelling, and of arithmetical computations common to real estate and appraisal practices.

(c) Applicants for licensing must submit an Initial Application and applicable related forms REA 3001 (Rev. 5/8/00), 3002 (Rev. 5/8/00), 3003 (Rev. 5/8/00) and 3004, (Rev. 5/8/00) which are incorporated herein by reference.

NOTE: Authority cited: Sections 11313 and 11340, Business and Professions Code. Reference: Sections 10153, 11340 and 11408, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3516 to new section 3561 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (c) filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3562. Examination Preparation Courses.

Courses designed solely to prepare an applicant to pass the licensing examination may not be used to meet the basic or continuing education requirements.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3517 to new section 3562 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3563. Evidence of Experience Qualifications.

(a) Documentation of work experience shall be made available to the Office by the applicant upon request.

(b) Documentation of work experience shall include but not be limited to one or all of the following:

(1) Log of Appraisal Experience Form REA 3004 (Rev. 5/8/00), which is incorporated herein by reference:

(2) Verification of ad valorem appraisal experience (Category 2) shall include certification from the appraiser's employer under penalty of perjury that the appraiser's experience was in real property appraisals.

(3) Substantiation of experience setting forth opinions of value of real property for tax purposes as an employee of a California county assessor's office or the California Board of Equalization (Category 9) shall include:

(A) Certification from the appraiser's supervisor, under penalty of perjury, that the appraiser's experience was in real property appraisals.

(B) A complete description of applicant's role in the preparation of appraisals, including, but not limited to, time period worked and types of properties.

(4) Samples of completed appraisals subject to the confidentiality provisions of USPAP. Applicants desiring return of any samples submitted to the Office shall include a written request at the time of submission, a true and correct copy of each sample submitted and a self-addressed envelope of sufficient size and with adequate postage for return of the original samples.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3518 to new section 3563 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (b)(1) filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
3. Repealer of subsections (b)(3)-(b)(3)(H), subsection renumbering and repealer of subsections (c)-(c)(2) filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

§ 3564. Evidence of Basic and Continuing Education Qualifications.

Verification required for basic and continuing education qualifications shall include the following information:

(1) Name of school;

(2) Name of student;

(3) Name of course;

(4) Date course was taken; and

(5) Course grade or other evidence of satisfactory completion.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3519 to new section 3564 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3565. Course Description Documentation.

(a) Upon request by the Office, the applicant shall submit course description documentation.

(b) Course description documentation shall include but not be limited to:

(1) Course syllabus;

(2) Course outline;

(3) Copies of the table of contents or copies of the index pages of the textbook used during the course; and

(4) Letters of verification from instructors, signed under penalty of perjury, verifying the following:

(A) Name of school;

(B) Name of student;

(C) Name of course;

(D) Date course was taken;

(E) Course grade or other evidence of satisfactory completion;

(F) Topic areas taught in the course; and

(G) Signature and date of instructor or other appropriate school official.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3520 to new section 3565 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3566. Challenge Courses.

Challenge courses are acceptable to meet basic education requirements only if they were completed prior to July 1, 1990.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Public Law 101-73 (FIRREA); and Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3521 to new section 3566 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3567. Petition For Equivalency Credit.

(a) An applicant may submit a petition for equivalency credit for those courses which have not been accredited pursuant to Article 9 of these regulations.

(b) The petition for equivalency credit shall be submitted with all applicable fees pursuant to Section 3582 on Petition for Equivalency Credit, Form REA 3005 (Rev. 5/8/00), which is herein incorporated by reference.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3522 to new section 3567 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (b) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3568. Provisional Licenses; Trainee Licenses and Supervising Appraiser Responsibilities.

(a) To obtain a Trainee License, applicants must satisfy the following minimum requirements:

(1) Education:

(A) Completion of basic education which covers the minimum number of hours and specific topics required by AQB for a residential level license and meets the minimum requirements of Section 3543; and

(B) 15 hours of USPAP which consists of the 15–hour National USPAP Course or its equivalent.

(C) All education must be completed within the five–year period immediately preceding the date the application was received by the office.

(2) Successful passage of the National Uniform Appraiser License examination or its equivalent.

(b) To accrue acceptable experience, trainee licensees must:

(1) Acquire experience pursuant to Section 3542.

(2) Work under the direct technical supervision of a licensed appraiser in good standing.

(3) Maintain an appraisal log in conformance with the requirements of Section 3563.

(c) Trainees must maintain copies of appraisal reports which appear on the log.

(d) Trainees shall comply with the continuing education requirements of Section 3543.

(e) The supervising appraiser must:

(1) Personally inspect the property with the trainee until the trainee is competent to make unsupervised inspections in accordance with the Competency Provision of USPAP for the type of property being appraised;

(2) Review the trainee's appraisal report;

(3) Accept responsibility for the appraisal report by signing and certifying that the report is in compliance with USPAP;

(4) Review and initial each page of the trainee's Log of Appraisal Experience Form REA 3004 (Rev. 5/8/00) and verify under penalty of perjury that the work was completed under his/her supervision; and

(5) Maintain records of the trainee's appraisals in accordance with USPAP.

(f) Supervising appraisers must be licensed at the certified level and be in good standing with the Office and may not supervise more than three appraisers at one time.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11341, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3523 to new section 3568 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (g) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
3. Repealer of subsections (a)–(b), subsection relettering, amendment of newly designated subsection (a)(1)(B) and new subsections (a)(1)(C) and (f) filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

§ 3569. Reciprocity.

(a) The Director may enter into reciprocal agreements with other states that have not been found to be out of compliance with ASC if the other states' requirements conform, at a minimum, with AQB criteria for certifying or licensing real estate appraisers.

(b) Reciprocal agreements shall provide that the two states may issue licenses or certificates without additional examination to licensees or certificate holders of the other state. Upon completion of the application process and payment of the established appraiser license fee, applicants shall submit documentation of current license or certificate and a certified letter of license history or its equivalent from the other state.

(c) The Director may terminate a reciprocal agreement if he or she determines that the other state:

(1) Is not assisting the Director in enforcement activity for the protection of California consumers.

(2) Is not maintaining or enforcing standards, qualifications, and examinations as prescribed by the AQB.

(d) The Director shall not issue any reciprocal license to an applicant from another state after the termination of the reciprocal agreement with that state. All licenses issued under the reciprocal agreement shall be void upon termination of the agreement. Thereafter, applicants and licensees from that state may then apply for a license in the same manner as California resident applicants.

(e) Appraisers who are licensed in another state that has not been found to be out of compliance by ASC and whose licenses are in good standing who wish to apply for equivalent California licenses shall complete and submit the following:

(1) Application for Reciprocal License Form REA 3025 (Rev. 5/8/00) and applicable related forms REA 3002 (Rev. 5/8/00), 3003 (Rev. 5/8/00) and 3004 (Rev. 5/8/00) as required in Section 3561, and form REA 3006 (Rev. 5/8/00);

(2) A Certificate of License History or its equivalent, not more than 30 days old, which shall be forwarded directly to the Office from the state in which the applicant is currently licensed;

(3) Details of any complaint filed against him or her with another licensing agency that was not found to be unfounded or unsubstantiated and any action taken by that agency; and

(4) Such other information as may be requested by the Director pursuant to these regulations, ASC policies and/or a written reciprocity agreement with any other jurisdiction.

(f) A license issued under this section shall be valid for the period of time that the applicant holds a valid, current license in his or her issuing state or the term of license provided in Section 3524 of these Regulations or until termination of the reciprocal agreement upon which the license was issued, whichever is earlier. Issuance fees for licenses to be issued with less than a full term pursuant to this section shall be prorated to the next highest semi–annual equivalent.

(g) The holder of a license issued pursuant to this section shall immediately notify the Office of any change in status of the license issued by another state. Any license issued pursuant to this section shall be void and immediately surrendered to the Office if the license issued by another state is not active at any time, if the other state is found not to be in compliance by ASC or if the reciprocity agreement between the other state and California is terminated.

(h) A reciprocal licensee shall comply with all statutes and rules governing licensed appraisers in California. Each reciprocal licensee shall immediately notify the Director of any disciplinary action taken in any other state in which the person holds a license or certificate.

(i) Any discipline imposed by the resident state against the licensee shall also constitute a disciplinary action against the licensee's reciprocal California license unless the director determines that a lesser or greater penalty is appropriate pursuant to this chapter.

NOTE: Authority cited: Sections 11313, 11314, 11340 and 11350, Business and Professions Code. Reference: Section 11341 and 11350, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3524 to new section 3569 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of section heading, section and NOTE filed 11–2–99; operative 12–2–99 (Register 99, No. 45).

3. Change without regulatory effect amending subsection (e)(1) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3570. Time Limits for Processing Applications.

(a) Within 90 days of receipt of the Initial Application, REA Forms 3001 (Rev. 5/8/00), 3002 (Rev. 5/8/00), 3003 (Rev. 5/8/00) and 3004, (Rev. 5/8/00), Upgrade Application, REA Form 3023 (Rev. 5/8/00), Renewal Application, REA Form 3012 (Rev. 5/8/00), Request for Temporary Permit, REA Form 3009 (Rev. 5/8/00), Course Provider Accreditation REA Form 3013 (Rev. 5/8/00), or Course Accreditation and Description REA Form 3014 (Rev. 5/8/00), the Office shall give written notice to the applicant that:

(1) the application is complete; or

(2) the application is deficient, describing what information is deficient and/or inadequate.

(A) An application is deficient if the applicant has not completed and provided the Office with all of the items required by Article 4 of these regulations, or any other information requested by the Office to complete the application.

(b) Within 90 days of receipt of a completed Request for Issuance, Form REA 3008 (Rev. 5/8/00), Application for Renewal, REA Form 3012 (Rev. 5/8/00) or Request for Temporary Practice Permit, REA Form 3009 (Rev. 5/8/00), Course Provider Accreditation REA Form 3013 (Rev. 5/8/00), or Course Accreditation and Description REA Form 3014 (Rev. 5/8/00), the Office shall issue or deny the requested license or accreditation provided that:

(1) The applicant has provided all required information;

(2) All required fees have been received by the Office; and

(3) Results of applicable criminal records checks have been received from the Department of Justice and/or Federal Bureau of Investigation, and any background check has been completed.

(c) The Office's completed review of an application for the two years immediately preceding this regulation has been approximately:

(1) a minimum of 90 days.

(2) a median of 120 days.

(3) a maximum of 150 days.

(d) A notice of deficiency pursuant to (a)(2) above shall include written notice of the following:

(1) That the applicant shall have the right to request a hearing by the Director on the grounds that:

(A) The Office did not send the applicant a deficiency notice or a completed application notice within the time provided in (a) above; or

(B) The Office did not issue the license or submit to the applicant a deficiency notice within the time provided in (b) above.

(2) A request for hearing under this section shall be made to the Director, in writing, clearly specifying the violations alleged, within 30 days from the date the notice of deficiency is mailed from the Office.

(3) If the Director determines that the Office exceeded the time limits without good cause, as defined in Section 15376 of the Government Code or exempted in Section 15377 of the Government Code, the applicant shall be reimbursed in full of any and all filing fees paid by the applicant and actually received by the Office.

(e) The time necessary to complete an informal conference in accordance with Section 3729 of these regulations, and/or a hearing pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, shall be excluded in determining whether or not the Office has complied with the 90 day requirement of subsections (a) and (b) above.

(f) Every adjudicatory hearing to determine whether an application should be granted shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) In no event shall a failure to comply with the requirements of this Section constitute grounds in and of itself for the issuance of a license or approval of accreditation.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Sections 15376 and 15378, Government Code.

HISTORY

1. Renumbering and amendment of former section 3525 to new section 3570 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsections (a) and (b) filed 9–18–2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3571. Due Diligence.

(a) An application shall be denied whenever an applicant does not exercise due diligence in the completion of an application or examination.

(b) Failure to exercise due diligence includes, but is not limited to, the following:

(1) Failure to appear for an examination within one year of issuance of the initial admit letter;

(2) Failure to complete an application within one year of submission to the office;

(3) Failure to respond to a written request from the office for additional information within 60 days of the request.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Sections 15376 and 15378, Government Code.

HISTORY

1. New section filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

Article 5. Fees

§ 3581. Fees.

(a) Fees paid to the Office shall be submitted in the form of a money order, certified check, cashiers' check, preprinted personal or company check, or governmental purchase order which shall clearly indicate the name of the applicant or licensee to whom it applies. Notwithstanding any other section, the Office may delay performance of any service until the personal or company check clears and the funds are deposited in the Office's accounts.

(b) Cash is not acceptable for payment of any fee.

(c) Payment of any fee, fine or penalty submitted in the form of a preprinted personal or company check which was subsequently dishonored by the issuing institution shall be submitted to the Office in the form of a money order, certified check, cashiers' check, or government purchase order.

NOTE: Authority cited: Sections 11313 and 11400, Business and Professions Code. Reference: Section 11400, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3526 to new section 3581 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of section and NOTE filed 11–5–98; operative 12–5–98 (Register 98, No. 45).

§ 3582. Fee Schedule.

(a) Fees are scheduled pursuant to Sections 11400 through 11408, Business and Professions Code.

(b) In addition to (a) above, the following is a schedule of additional fees:

1) Application Review (all classifications–new, renewal, upgrades)	$150
2) Issuance Fees (new and renewals)	
Trainee Level	$300
Residential Level	$300
Certified Levels	$375
3) Issuance Fees (upgrades)	
To Certified Levels	$75
4) Late Renewal Fee (all license levels)	
0 – less than 12 months	$125
5) Background Investigation Fees	$70
6) Child Support Review Fee	$10
Reinstatement After Child Support Suspension	$140

7) Registry Fees (every two years)	
Federal ($25 per year)	$50
State Processing	$25
8) Temporary Practice Permit	$80
9) Petition for Equivalency (per course)	$45
10) Basic Education Provider Fees	
Course Provider Application Review Fee	$150 per submission
Course Review Fee	$350 per course
Multiple Courses Review Fee (Submitted at same time)	
1 to 5 courses	$350 per course
6 or more courses	$250 per course for each course over 5 courses
11) Continuing Education Provider Fees	
Course Provider Application Review Fee	$150
Course Review Fee	
Up to 14 hours	$50
15 to 29 hours	$100
Each additional 14 hour segment or portion thereof	$50
12) Miscellaneous Fees	
Certificate of Good Standing	$15
Certification of Documents	$5
Change of Name (Business or Personal)	$10
Duplicate License	$50 with certification of loss
Duplicate Admit Letter	$10 with certification of loss
Dishonored Check Fee	$25 plus collection costs
Federal and State Laws & Regulations Course Materials Package	$50 plus tax and postage
Laws & Regulations Package	$15 plus tax and postage
Letter of License History	$40
Photocopy Costs	$.10 each page plus postage
Retrieve File/Records from Archives	$25
State Registry (available on disk only)	
Full List	$55 plus tax and postage
Special Request	$90 plus tax and postage

(c) Notwithstanding any other provision, a license shall be automatically suspended if payment of any fees is dishonored by the issuing institution for any reason. The license shall remain suspended and shall not be renewed until receipt of all accumulated fees and penalties. Such a suspension shall be in addition to and not in place of any penalties imposed pursuant to this chapter and shall not relieve the licensee of his or her continuing education requirements.

(d) The fee to take an examination or reexamination for a license shall be set at an amount not to exceed the cost to the office as determined by competitive bid. The director may provide that the applicant pay the fee directly to the examination provider.

NOTE: Authority cited: Sections 11350, 11400, 11401, 11402, 11403, 11404, 11405, 11406 and 11422, Business and Professions Code; and Section 11350.6, Welfare and Institutions Code. Reference: Sections 11350, 11401, 11402, 11403, 11404 and 11406, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3527 to new section 3582 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsection (b) filed 6–15–2000; operative 7–15–2000 (Register 2000, No. 24).

The following section shall be in effect with the operable date of these regulations and shall be operable through June 30, 2010, and shall thereupon expire:

§ 3583. Temporary Reduction in Issuance Fees.

Issuance fees specified in section 3582(b)(2) notwithstanding, the issuance fees for new and renewal licenses shall be

(a) Trainee Level	$150
(b) Residential Level	$150
(c) Certified Levels	$200

NOTE: Authority cited: Sections 11350, 11400, 11401, 11402, 11403, 11404, 11405, 11406, 11407 and 11422, Business and Professions Code; Section 11350.6, Welfare and Institutions Code. Reference: Sections 11350, 11401, 11402, 11403, 11404, 11406 and 11407, Business and Professions Code.

HISTORY

1. New section filed 8–8–2006; operative 9–7–2006 (Register 2006, No. 32).

Article 6. Change/Conversion Procedures

§ 3601. Change in the Status of an Application for License.

Applicants may change the status of their application during the application review process pursuant to the following:

(a) If an applicant wishes to change the status of his or her application to a higher classification and no examination admit letter has been mailed, the applicant must submit the following information to the Office:

(1) Written request to change the application stating the new classification requested;

(2) Additional education and/or experience documentation necessary to qualify at the higher classification; and

(3) All applicable fees pursuant to Section 3582.

(b) If an applicant has received his or her examination admit letter or has passed the examination but has not been issued a License and wishes to change the status of the application to a higher classification, the applicant must submit the following to the Office:

(1) Written request to change the application stating the new classification requested;

(2) Original examination admit letter as issued by the Office or the original examination results issued by the test center, plus the difference in or new examination fee, as appropriate;

(3) All applicable fees pursuant to Section 3582; and

(4) Additional education and/or experience documentation as necessary to qualify at the higher classification.

(c) If an applicant wishes to change his or her application to a lower classification and the examination has been taken, the applicant must submit the following to the Office:

(1) Written request to change the application stating the new classification requested; and

(2) All applicable fees pursuant to Section 3582.

(d) If an applicant wishes to change his or her application to a lower classification and the examination has not been taken, the applicant must submit the following to the Office:

(1) Written request to change the application stating the new classification requested.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3528 to new section 3601 filed 11–1–96; operative 11–1–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3602. Change in the Status of License.

(a) If a licensed appraiser wishes to change the status of his/her license to a higher classification, the appraiser must submit the following information to the Office:

(1) Completed Upgrade Application Forms REA 3023 (Rev. 5/8/00) and 3001 (Rev. 5/8/00), 3002 (Rev. 5/8/00), 3003 (Rev. 5/8/00) and

3004, (rev. 5/8/00), as applicable (excluding the fingerprint card) pursuant to Section 3561;

(2) All applicable fees; and

(3) Education and/or experience documentation as necessary to qualify at the certified residential or certified general level.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3529 to new section 3602 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (a)(1) filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3603. Converting a Trainee License to a Full License or Higher Classification.

Trainee licensed appraisers wishing to convert to a residential license or higher classification must submit the following to the Office:

(1) Upgrade Application REA Forms 3023 (Rev. 5/8/00) and 3001 (Rev. 5/8/00), 3002 (Rev. 5/8/00), 3003 (Rev. 5/8/00) and 3004, (Rev. 5/8/00).

(2) All applicable fees as required;

(3) If the Trainee License was obtained based on education, documentation shall be submitted to verify completion of the required hours of experience in accordance with Section 3563.

(4) Notwithstanding subsections (1) and (3), the applicant shall submit such documentation as the Office deems necessary to determine whether or not the holder of the trainee license meets the minimum requirements for the license level to which he or she wishes to convert.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3530 to new section 3603 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (1) filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
3. Amendment of section heading and section filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

Article 7. Examinations

§ 3621. Examinations.

(a) Examination results shall be valid for one year from the date issued.

(b) The licensing examinations shall be held in locations and at times as designated by the Office.

(c) As a condition for entry to the examination, each applicant shall be required to present one of the following forms of identification each of which must bear a photograph, signature and birth date of the applicant:

(1) A currently valid drivers license or identification card issued by a state Department of Motor Vehicles or equivalent agency;

(2) A currently valid military identification card; or

(3) A currently valid identification document issued by the United States Immigration and Naturalization Services.

(d) Also as a condition for entry to the examination, each applicant shall be required to present the original examination admit letter as issued by the Office.

NOTE: Authority cited: Sections 11313, 11314, 11340 and 11408, Business and Professions Code. Reference: Sections 123 and 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3531 to new section 3621 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3622. Re-Examination.

(a) Applicants who fail an examination may apply for re-examination by submitting the following:

(1) Request for Re-Examination, Form REA 3007 (Rev. 5/8/00), which is herein incorporated by reference; and

(2) All applicable fees pursuant to Section 3582.

(b) Applicants shall not be permitted to take any subsequent examination without a scheduled time and payment of applicable fees.

(c) Applicants shall not be allowed more than 5 attempts to pass the examination in any 12-month period.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3532 to new section 3622 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsection (a)(1) filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).
3. New subsection (c) filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

Article 8. Issuance Procedures

§ 3641. Issuance of License.

Applicants requesting the issuance of a license shall submit an Application for Issuance of License, Form REA 3008 (Rev. 5/8/00), which is herein incorporated by reference, examination results and all applicable fees within one year of successful completion of the examination.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Sections 11340 and 11408, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3533 to new section 3641 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending section filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

Article 9. Basic and Continuing Education Accreditation

§ 3661. General Requirements for Basic and Continuing Education Accreditation.

(a) Basic and continuing education accreditation requirements shall be as follows:

(1) Each course sponsor shall provide a copy of each of the following to each student upon enrollment:

(A) Course outline;

(B) Enrollment fee refund policy; and

(C) Grading policy.

(2) Each completion certificate shall be completed under penalty of perjury and include the following:

(A) Office course approval number;

(B) Name and address of student;

(C) Course title;

(D) Statement that course was either correspondence or classroom attended;

(E) Dates of course completion and date of successful completion of basic education final examination;

(F) For continuing education courses, a statement that the student was in attendance at least 90% of class time;

(G) Identity and signature of verifier of course completion; and

(H) The course sponsor may include such additional information in this document as it deems necessary.

(3) Participants shall be physically present during at least 90% of the offering time exclusive of the time allocated to the administering of a basic education final examination; and

(4) Each instructor shall have at least one of the following:

(A) A bachelor's degree or higher degree in a field related to real estate appraising from a school listed as an institution of higher learning by the

U.S. Office of Education, or from a comparable school of a foreign country;

(B) A valid teaching credential or certificate authorizing the holder to teach in the field of knowledge covered in the offering;

(C) Five years full-time experience in the field being taught; or

(D) A combination of full-time experience and full time college-level education totaling at least five years.

(b) In addition to (a) above, requirements for basic education accreditation shall be as follows:

(1) Each course shall have a final exam per AQB established appraiser qualification criteria; and

(2) Examination questions to be included in the final examination shall not be reviewed with students before, during or after the course.

(3) Each course shall meet the minimum course length requirements established by AQB.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3534 to new section 3661 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3662. Accreditation Application.

(a) Course providers desiring to be accredited and/or to have a course accredited shall submit Course Provider Accreditation, REA Form 3013 (Rev. 5/8/00), Course Accreditation and Description, REA Form 3014 (Rev. 5/8/00) and OREA Topic Matrix, REA Form 3015 (Rev. 5/8/00), which are herein incorporated by reference, as applicable.

(b) The application shall be signed by the course provider's Chief Executive Officer.

(c) The Chief Executive Officer of the course provider may delegate authority to sign the Course Provider Accreditation, REA Form 3013 (Rev. 5/8/00), Course Accreditation and Description, REA Form 3014 (Rev. 5/8/00) and OREA Topic Matrix, REA Form 3015 (Rev. 5/8/00), by filing with OREA a written delegation of authority to act on behalf of the course provider for accreditation matters.

(d) Only one such delegation of authority shall be valid at any point in time for the education activities of the course provider within a particular state.

(e) The delegation of authority shall be valid for a maximum of four years, and may be revoked by the Chief Executive Officer by filing a written revocation of the delegation of authority with OREA. A new delegation of authority, in writing, must be submitted to, and received by, OREA within 30 days of a change in the course provider's Chief Executive Officer.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3535 to new section 3662 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Change without regulatory effect amending subsections (a) and (c) filed 9-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 38).

§ 3663. Additional Approval.

(a) Proposed course offerings may also require the approval of the Council of Private Post Secondary and Vocational Education pursuant to the Private Post Secondary and Vocational Education Reform Act of 1989 (Education Code Sections 94300, et seq.) If such approval is required by the Council of Private Post Secondary and Vocational Education, the course provider shall forward a copy of said approval to the Office as part of their Application.

(b) It is the responsibility of the course provider to ensure that any such responsibilities under that Act are satisfied, and that OREA is provided satisfactory notification.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3536 to new section 3663 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3664. Material Change in Education Course Offering, School Management or School Operating Policies.

(a) Any proposed material change to an accredited education offering, school management or school operating policies shall be submitted by the provider to the Office for consideration and approval prior to use, together with a new accreditation application and fee.

(b) "Material change" means a significant deviation in one or more aspects from the course offering, school ownership, management or operating policies as approved by the Office, including but not limited to a change in curriculum, course length, form or substance of the final examination, workbooks, texts or syllabi, but not including changes designed exclusively to reflect recent changes in statutes, regulations or decisional law;

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3537 to new section 3664 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3665. Record Keeping.

(a) The course provider shall maintain a student record for each participant for a period of at least five years from completion of the course. The record shall include, at a minimum, the following information:

(1) The Office's accreditation number for the offering;

(2) Name and address of each participant;

(3) Course title and hours of credit approved;

(4) Date(s) of course and date course is completed;

(5) Name and address of course provider;

(6) Identity of verifier of attendance; and

(7) Course grade or other evidence of satisfactory completion.

(b) The course provider shall maintain business records for a period of at least five years. The records shall include, at a minimum, the following information:

(1) Business and mailing address of course provider as on file with the Office;

(2) Written records of attendance and grades for each student; and

(3) The principal place of business or the mailing address at which each of the accredited basic education and continuing education instructors can be contacted.

(c) Upon receipt of a request from the Director, the records specified in this section shall be submitted to the Office within 30 days.

(d) Whenever there is a change in the business or mailing address of the course provider, the course provider shall notify the Director in writing within 10 days of the change.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3538 to new section 3665 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 26.

§ 3666. Advertising.

Any advertising by or on behalf of a course provider for real estate or real estate appraisal related educational services shall:

(a) Clearly identify the provider as being an OREA approved real estate appraisal educational course provider and the provider's OREA approval number;

(b) Clearly identify those courses which have been accredited by OREA and their OREA approval number, or, in the alternative, include:

(1) A clear statement that not all courses offered by the course provider are necessarily OREA approved; and

(2) A clearly legible telephone number and address for the course provider which may be utilized by those interested in determining if a specif-

ic course offered by the provider has been approved by OREA, and its approval number.

(c) Clearly contain the date of initial publication or distribution;

(d) Not state or imply an endorsement of the course provider or any courses by OREA or the State of California other than the fact of accreditation as indicated in (a) and (b) of this section;

(e) Not include any false, misleading or deceptive information;

(f) Not contain any asterisk or other reference symbol to contradict or to change the ordinary meaning of the material in the body of the advertisement; and

(g) Not contain any offers or inducements precluded by law.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Sections 11360 and 11406, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3667. Subcontractors, Agents and Franchisees.

(a) Course providers shall be responsible for the actions of their subcontractors, agents and franchisees for activities subject to this article and shall ensure that said persons and entities comply with this article's provisions.

(b) Contracts entered into by or on behalf of course providers for services subject to this article shall contain a requirement that the service provider comply with the provisions of this Article.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Sections 11360 and 11406, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3668. Denial or Withdrawal of Education Accreditation.

(a) A course shall not be accredited if the Director determines that the course or course provider fails to satisfy the requirements of Article 9 of these regulations.

(b) Accreditation shall be withdrawn if the Director determines that the course or course provider fails to satisfy or has violated the requirements of Article 9 of these regulations.

(c) The process for denial or withdrawal shall be as follows:

(1) The determination by the Director shall be submitted to the course provider in writing setting forth the reasons for the determination;

(2) Within 30 days of receipt of the Director's written determination, the course provider may submit a written request for a hearing;

(3) The Director shall hold a hearing within 90 days of receipt of the written request for a hearing unless another hearing date is agreed upon by both parties;

(4) The Director shall issue a written decision within 30 days of completion of the hearing; and

(5) If a hearing is not held pursuant to (3) above or a decision is not issued pursuant to (4) above, accreditation will be deemed to have been given by the Director.

(d) Accreditation shall automatically expire after four years or any time the course has not been offered by the course provider in two consecutive years.

(e) In any hearing, the burden of proving that the course complies with the requirements of Article 9 of these regulations is on the party seeking the accreditation.

(f) No applicant shall be given credit for any course work commenced after the effective date of withdrawal of accreditation.

NOTE: Authority cited: Sections 11313, 11314 and 11340, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3539 to new section 3668 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsections (a)–(b) filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

§ 3669. Course Credit After Revocation.

If an offering was accredited at the time of registration by an appraiser, credit for the offering shall be given to the appraiser at the time of initial licensure or upon renewal notwithstanding the fact that approval may have been revoked at the time that the applicant successfully completed the offering except in the event of collusion.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Section 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3540 to new section 3669 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

Article 10. Renewal Procedures

§ 3681. Renewal Application.

(a) A license may be renewed by submitting the following to the Office:

(1) Appropriate fees including state and federal registry fees pursuant to Section 3582;

(2) Every other renewal period, proof of completion of approved continuing education by one of the following:

(A) Official transcript;

(B) Report card; or

(C) Completion certificates.

(3) Every renewal period, proof of completion of the 7-hour National USPAP Update Course;

(4) REA Form 3012 (Rev. 5/8/00) Renewal Application which is herein incorporated by reference.

(b) The renewed license shall be valid for a maximum of two years from the date of expiration of the prior license, provided the Renewal Application is received by the Office before midnight of the last day of the period for which the previous license was issued, accompanied by the applicable renewal fees and evidence of good faith compliance with the provisions of this Article.

(c) Complete applications for renewal of licenses should be submitted to the Office at least 90 days prior to the license expiration date. However, applications for renewal shall not be accepted by the Office more than 180 days prior to the expiration of the existing license.

NOTE: Authority cited: Sections 11313, 11314, 11340, 11341, 11360 and 11361, Business and Professions Code. Reference: Sections 11340, 11341, 11360 and 11361, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3541 to new section 3681 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsections (a)(2) and (b) filed 6-15-2000; operative 7-15-2000 (Register 2000, No. 24).
3. Amendment of subsection (a)(1), new subsection (a)(3) and subsection renumbering filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

§ 3682. Late Renewals.

(a) If an appraiser fails to renew his or her license prior to its expiration, the appraiser may renew the license within two years after expiration of the previously held license by satisfying all of the requirements for renewal of the license and by the payment of all applicable fees.

(b) Appraisals in federally related transactions may not be performed during the two year grace period immediately following the date the appraiser's license expires, unless and until a renewed license is issued.

(c) An appraiser applying for late renewal shall, prior to the submission of his or her application for late renewal, complete at least 10 hours (prorated semiannually) of continuing education for each year since the expiration of the license for the period occurring up to and including December 31, 1997, and at least 14 hours (prorated semiannually) of continuing education for each year since the expiration of the license for the period occurring on or after January 1, 1998, in addition to meeting the requirements of Section 3543.

(d) Any person whose license expires and does not renew within two years of the date of expiration, must submit the following:

(1) A new application;

(2) Proof of compliance with the requirements for new applicants in existence at the time of the new application; and

(3) All applicable fees.

NOTE: Authority cited: Sections 11313, 11314 and 11361, Business and Professions Code. Reference: Sections 11341 and 11360, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3542 to new section 3682 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment filed 6-15-2000; operative 7-15-2000 (Register 2000, No. 24).
3. Amendment of subsections (a)-(b) and (d) filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

Article 11. Rules of Professional Conduct

§ 3701. Standards of Professional Appraisal Practice.

Every holder of a license under this part shall conform to and observe the Uniform Standards of Professional Appraisal Practice (USPAP) and any subsequent amendments thereto as promulgated by the Appraisal Standards Board of The Appraisal Foundation which standards are herein incorporated into these regulations by reference as if fully set forth herein.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Chapter 491 Statutes of 1991, Section 4; Business and Professions Code 11340(c); Section 1103 of Public Law 101-73 (12 USC 3301, etc.) Title XI (Real Estate Reform Amendment).

HISTORY

1. Renumbering and amendment of former section 3543 to new section 3701 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3702. Special Qualifications of Appraisers.

(a) The Director finds and declares as follows:

(1) That the profession of real estate appraisal is vested with a fiduciary relationship of trust and confidence as to clients, lending institutions, and both public and private guarantors or insurers of funds in federally-related real estate transactions and that the qualifications of honesty, candor, integrity, and trustworthiness are directly and substantially related to and indispensable to the practice of the appraisal profession; and

(2) Every holder of a license to practice real estate appraisal shall be required to demonstrate by his or her conduct that he or she possesses the qualifications of honesty, candor, integrity, and trustworthiness.

(b) The Director may require such proof as he may deem advisable concerning the special qualifications of an applicant for or holder of an appraisers' license.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Chapter 491 Statutes of 1991, Section 4; Business and Professions Code 11340(c); Section 1103 of Public Law 101-73 (12 USC 3301, etc.) Title XI (Real Estate Reform Amendment).

HISTORY

1. Renumbering and amendment of former section 3544 to new section 3702 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3703. Complaints of Unlawful or Unprofessional Conduct.

Any person may file a complaint alleging that any applicant for or holder of a license has committed acts or omissions constituting unethical or unprofessional conduct by following the procedure set forth in Section 3726 (Initiation of Disciplinary Proceedings). Such complaint may, but need not, specify the provisions of law, regulations or USPAP alleged to have been violated.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Sections 11313 and 11314, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3546 to new section 3703 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 26.

§ 3704. Employees of OREA.

An employee of the Office shall not perform appraisals except in the performance of his or her official duties.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Section 11340, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3705. Responsibility for Appraisal Reports, Signatures.

(a) Every appraisal report subject to the Uniform Standards of Professional Appraisal Practice upon final completion shall bear the signature and license number of the appraiser and of the supervising appraiser, if appropriate. The affixing of such signature and number constitute the acceptance by the appraiser and supervising appraiser of full and personal responsibility for the accuracy, content, and integrity of the appraisal under Standards Rules 1 and 2 of USPAP.

(b) Every review appraisal report upon final completion shall bear the signature and license number of the reviewer. The affixing of such signature and number shall constitute acceptance by the reviewer of responsibility for the review under Standard Rule 3 of USPAP.

(c) The license number of the appraiser, and of the review appraiser if the report is a review, shall appear with each signature throughout the appraisal or review document.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Chapter 491 Statutes of 1991, Section 4; Business and Professions Code 11340(c); Section 1103 of Public Law 101-73 (12 USC 3301, etc.) Title XI (Real Estate Reform Amendment); USPAP Ethics Provision, Record Keeping.

HISTORY

1. Renumbering and amendment of former section 3549 to new section 3705 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

Article 12. Discipline

§ 3721. Revocation, Suspension, Denial of Licenses.

(a) The Director may issue a citation, order of abatement, assess a fine or private or public reproval, suspend or revoke any license, and/or may deny the issuance or renewal of a license of any person who has:

(1) Been convicted of a felony or any crime which is substantially related to the qualifications, functions, or duties of the profession of real estate appraisal;

(2) Done any act involving dishonesty, fraud or deceit with the intent to benefit himself or another, or to injure another;

(3) Been convicted for a commission or solicitation of a criminal act which involved or threatened bodily harm to others;

(4) Done any act which if done by the holder of a license to practice real estate appraisal would be grounds for revocation or suspension of such license;

(5) Knowingly made a false statement of material fact required to be disclosed in an application for a license authorizing the practice of real estate appraisal;

(6) Violated any provision of USPAP;

(7) Violated any provision of the Real Estate Appraisers' Licensing and Certification Law, Part 3 (commencing with Section 11300) of Division 4 of the Business and Professions Code, or regulations promulgated pursuant thereto; or any provision of the Business and Professions Code applicable to applicants for or holders of licenses authorizing appraisals;

(8) Been prohibited from participating in the affairs of an insured depository institution pursuant to Section 19(a) of the Federal Deposit Insurance Act (12 U.S.C. Section 1829.); or

(9) Submitted a financial instrument to OREA for the payment of any fee, fine or penalty which instrument is subsequently dishonored by the issuing institution due to an act or omission of that person.

(b) Before issuing any private or public reproval or denying, suspending, or revoking any license issued or issuable under the provisions of the Real Estate Appraisers Licensing and Certification Law or these regulations, the Office shall proceed as prescribed by Chapter 5 (commencing

with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (the Administrative Procedure Act) and the Office shall have all the powers granted therein.

(c) Any person issued a citation containing a fine or order of abatement may contest the citation by filing a written notice with the Office within 30 calendar days that states with specificity the basis of the appeal. Upon receipt of such notice, the Office shall proceed as prescribed by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (the Administrative Procedure Act) and the Office shall have all the powers granted therein.

NOTE: Authority cited: Sections 11313, 11314 and 11315, Business and Professions Code. Reference: Sections 480, 490, 11320 and 11321, Business and Professions Code; Administrative Procedure Act, Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

HISTORY

1. Renumbering and amendment of section heading and former section 3550 to new section 3721 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.
2. Amendment of subsection (a)(9) filed 11-5-98; operative 12-5-98 (Register 98, No. 45).

§ 3722. Criteria of Substantial Relationship.

(a) A crime or act shall be deemed to be substantially related to the qualifications, functions or duties of an appraiser if the act or crime was willful or intentional or involved the use of fraud, deceit or dishonesty for profit or gain in any of the following situations:

(1) Taking, appropriating or retaining the funds or property of another;

(2) Forging, counterfeiting or altering any instrument affecting the rights or obligations of another;

(3) Evasion of a lawful debt or obligation, including but not limited to tax obligations;

(4) Traffic in any narcotic or controlled substance in violation of law;

(5) Driving under the influence of alcohol or drugs, while conducting business related to real estate appraisals; conviction of felony driving under the influence of alcohol or drugs; or conviction of two or more misdemeanor driving under the influence of alcohol or drugs within any three year period.

(6) Violation of a relation of trust or confidence;

(7) Theft of personal property or funds;

(8) Crimes of violence or threatened violence against persons or property; or

(9) Lying on the appraisal license application and/or cheating on the examination.

(b) An act or crime shall be deemed to be substantially related to the functions, duties or qualifications of an appraiser if it involves any willful violation of the Real Estate Appraisers' Licensing and Certification Act or provisions of the Business and Professions Code applicable to appraisers.

(c) The weight to be accorded to a substantially related crime or act under (a) or (b) shall be determined by application of the following standards:

(1) The extent to which the particular acts or omissions have adversely affected other persons, including but not limited to lenders, clients, employers or other persons; and the probability that such adverse effects will continue;

(2) The recency or remoteness in time of the acts or omissions;

(3) The type of license applied for or held by the person involved;

(4) The extenuating or aggravating circumstances surrounding the acts or omissions;

(5) The motivation of the acts or omissions, whether praiseworthy or blameworthy;

(6) The probability that the questioned acts or omissions will continue or be repeated; and

(7) The extent to which disciplinary action may inflict an adverse impact or chilling effect upon the constitutional rights of the person involved or other licensed persons.

NOTE: Authority cited: Section 11313 and 11314, Business and Professions Code. Reference: Sections 481 and 482, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3551 to new section 3722 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3723. Criteria of Rehabilitation.

(a) Upon a determination pursuant to Section 3722 that a substantial relationship exists between particular acts or omissions and the qualifications, functions or duties authorized or to be authorized by a license applied for or held, the Director shall consider all competent evidence provided by the applicant or licensed appraiser or known to the Director, consisting of testimony or other facts showing:

(1) The effect of the passage of time since the most recent conviction or offense;

(2) Restitution to any person who has suffered monetary losses through "substantially related" acts or omissions of the Applicant;

(3) Judicial relief from the consequences of criminal convictions resulting from immoral or antisocial acts including but not limited to Release from Probation (PC 1203.4), Certificate of Rehabilitation (PC 4852.01), finding of factual innocence (PC 841.8, 851.85), Diversion (completed), or other comparable orders of a court, including federal courts;

(4) Successful completion or early discharge from probation or parole;

(5) Abstinence from the use of controlled substances or alcohol for not less than two years if the crime or offense is attributable in part to the use of controlled substances or alcohol;

(6) Payment of any fine or other monetary penalty imposed in connection with a criminal conviction or quasi-criminal judgment;

(7) Stability of family life and fulfillment of parental and familial responsibilities subsequent to the conviction or offense;

(8) Completion of, or sustained enrollment in, formal education or vocational training courses for economic self-improvement;

(9) Discharge of, or bona fide efforts toward discharging, adjudicated debts or monetary obligations to others;

(10) Correction of business practices resulting in injury to others or with the potential to cause such injury;

(11) Significant or conscientious involvement in community, church or privately-sponsored programs designed to provide social benefits or to ameliorate social problems;

(12) New and different social and business relationships from those which existed at the time of the crime or offense; or

(13) Change in attitude from that which existed at the time of the crime or offense as evidenced by any or all of the following:

(A) Testimony of applicant or licensed appraiser;

(B) Evidence from family members, friends or other persons familiar with applicant's previous conduct and with his or her subsequent attitudes and behavioral patterns;

(C) Evidence from probation or parole officers or law enforcement officials competent to testify as to applicant's social adjustments; or

(D) Evidence from psychiatrists or other persons competent to testify with regard to psychiatric or emotional disturbances.

(b) The enumeration of criteria in (a) does not preclude the consideration of other competent evidence of rehabilitation.

NOTE: Authority cited: Sections 482, 11313 and 11314, Business and Professions Code. Reference: Sections 482 and 11340, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3552 to new section 3723 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3724. Citations for Unprofessional Conduct.

(a) Where the Director has verified a notice of acts or omissions by a licensed appraiser which constitute a violation of statute, regulation or USPAP, he/she may issue a citation in writing which describes with particularity the nature of the violation and including specific reference to the law, regulation or professional practice standard determined to have been violated. The citation may include a notice of abatement fixing a reasonable period of time for abatement of the violation, assessment of

private or public reproval, suspension, revocation, restriction of license, fine or any combination of these actions.

(b) Fines shall not exceed $10,000 per incident. In assessing a fine, the Director shall give due consideration to:

(1) The gravity of the violation;

(2) The good or bad faith of the person cited;

(3) The history of previous violations;

(4) Evidence that the violation was willful;

(5) The extent to which the cited person has cooperated with the Office;

(6) The extent to which the cited person has mitigated or attempted to mitigate any loss or potential loss caused by the violation; and

(7) Such other matters as the Director determines are in the interest of justice.

(c) Citations issued hereunder shall be subject to review as provided in subsection (b) of Section 3721.

NOTE: Authority cited: Sections 11313, 11314 and 11315, Business and Professions Code. Reference: Section 11314, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3553 to new section 3724 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

§ 3725. Unlicensed Activity.

Where the Director determines that a person is acting in the capacity of a licensee under the jurisdiction of the Office in violation of Section 11320 of the Business and Professions Code, and said person commits acts or omissions which constitute a violation of statute or these regulations, the Director may issue a citation to that person in accordance with Section 3724. Any sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

NOTE: Authority cited: Sections 11313, 11314, 11315 and 11320, Business and Professions Code. Reference: Section 11314, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3726. Initiation of Disciplinary Proceedings.

(a) Any person may request the Director to initiate disciplinary action against an applicant or a licensed appraiser as follows:

(1) The request shall be in writing, shall identify the applicant or licensed appraiser to be charged and shall set forth in ordinary and concise language the particular acts or omissions with which the applicant or licensed appraiser is charged in such detail as is reasonably necessary to enable the Director to understand the nature of the charges and their significance. Such request may, but need not, specify the statutes or regulations alleged to have been violated;

(2) Where the acts or omissions alleged are not within the personal knowledge of the person filing the request, such request shall be accompanied by verified statements of facts from one or more persons who do have personal knowledge of the acts or omissions alleged;

(3) Each such request shall be dated and signed and shall include the following verification: "I certify under penalty of perjury of the laws of the State of California that the facts stated herein are true and correct", and shall show the county or place where subscribed.

(b) The complainant shall be notified that a confidential investigation has been commenced within ten working days of receipt of the verified complaint; and shall be notified of final action taken on the complaint.

(c) If the complaint is not within the jurisdiction of the Director, or if the Director is unable to make a satisfactory disposition of the complaint, the Director, if appropriate, shall transmit the complaint, together with any appropriate evidence or information he or she has concerning the complaint to the agency, public or private, whose authority in the opinion of the Director will provide the most effective means to secure the relief sought. The Director shall notify the complainant of such action and of any other appropriate means which may be available to the complainant to secure relief.

(d) An investigation may be initiated by the Director upon information and belief.

NOTE: Authority cited: Section 11314, Business and Professions Code; and Section 11180, Government Code. Reference: Sections 480, 490 and 11320, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3554 to new section 3726 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 26.

§ 3728. Confidential Report of Investigation.

(a) Each complaint shall result in a confidential investigative report showing a summary of the acts and/or omissions alleged, and a summary of the supporting evidence together with a recommendation for appropriate enforcement action, if any.

(b) Where the confidential investigation report shows that the allegations are supported by credible evidence that a violation of law or regulations has occurred and that the applicant or licensed appraiser has committed the violation, and that the violation is substantially related to the qualifications, duties, or functions of an appraiser, the Office shall issue a citation and/or order of abatement, or shall file an accusation or statement of issues against the applicant or licensed appraiser.

(c) Where the confidential investigative report shows that the allegations, even if true, do not constitute a violation of the law or regulations, that the allegations are not supported by sufficient credible evidence, or that the facts show a complete defense or legal justification, the investigation shall be closed.

(d) Notwithstanding any other provision of this chapter, the Director may release information concerning confidential investigations and complaints to a law enforcement agency or to another regulatory agency to which the appraiser has applied for licensure.

NOTE: Authority cited: Sections 11314 and 11315, Business and Professions Code. Reference: Sections 480, 490 and 11320, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3555 to new section 3728 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 26.

§ 3729. Conference to Consider Allegations, Notice.

(a) Not less than 30 calendar days after a Notice of Conference has been issued, unless the applicant or licensed appraiser requests an earlier date, an informal conference may, at the discretion of the Office, be held, in which the applicant or licensed appraiser shall have an opportunity to show why the Office should not proceed with a disciplinary action.

(b) The conference shall be closed to all except the applicant or licensed appraiser and his or her representative, if any, and the person or persons designated by the Director. The office shall not release or give out any information received in the conference or in connection with the confidential investigation report to any person not authorized by law to receive such information.

(c) Within 60 calendar days after the conference, the licensed appraiser shall be given written notice either that:

(1) The Office has determined that further action or proceedings are not warranted;

(2) The matter has been resolved by stipulation or agreement, together with the terms and conditions thereof; or

(3) An accusation or statement of issues will be filed or a citation issued against him or her.

NOTE: Authority cited: Section 11314, Business and Professions Code. Reference: Sections 11503 and 11504, Government Code.

HISTORY

1. Renumbering and amendment of former section 3556 to new section 3729 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 26.

§ 3730. Suspension of License After Informal Conference.

(a) The Director may, after an informal conference, suspend the license of any person who procured the issuance of a license for himself or herself by fraud, misrepresentation, deceit, or by the making of any material misstatement of fact in his or her application for such license.

(1) The authority of the Director to order such suspension of a license shall expire 180 days after the date of issuance of said license.

(2) The suspension itself shall remain in effect only until the effective date of a decision of the Director after a hearing conducted pursuant to these regulations.

(b) The Director may, after an informal conference, suspend the license of any person who is convicted of a crime which is, or that there is probable cause to believe that it is, substantially related to the duties of an appraiser and continuation of the licensed activity poses a serious threat of harm to the health, safety or welfare of the public.

(c) The Director may, after an informal conference, suspend the license of any person who is alleged to have committed an act, or there is probable cause to believe that an act has been committed that is substantially related to the duties of an appraiser and continuation of the licensed activity poses a serious threat of harm to the health, safety or welfare of the public.

(d) Notwithstanding Section 3729, an informal conference regarding allegations subject to this section may be held not less than 10 calendar days after a Notice of Conference has been issued, unless the applicant or licensed appraiser requests an earlier date.

(e) Upon issuance of a suspension under this section, the Director shall proceed as prescribed by Chapter 3 (commencing with Section 490) of Division 1.5 of the Business and Professions Code and the Office shall have all the powers granted therein.

NOTE: Authority cited: Sections 11313, 11314 and 11315, Business and Professions Code. Reference: Section 494, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3731. Renewal of Suspended or Revoked License.

(a) A license which is suspended is subject to expiration.

(b) A licensee whose license is suspended may apply for renewal as provided in this chapter. Such renewal does not entitle the licensee, while the license remains suspended, and until it is reinstated, to engage in the licensed activity, or in any other activity or conduct in violation of the order or judgement by which the license was suspended. The holder of a suspended license shall comply with all continuing education requirements.

(c) A license which is revoked shall not be renewed. Petition for reinstatement may be made by the former licensee not less than one year after revocation or denial of a prior petition for reinstatement by submitting a new application for licensure in accordance with Article 4, including the payment of all fees in accordance with then existing requirements, plus any outstanding fees, fines or penalties. The former licensee shall include with the application a written statement signed and dated under penalty of perjury detailing how the Criteria of Rehabilitation contained in Section 3723 apply to his or her circumstances.

NOTE: Authority cited: Sections 11313, 11314, 11320, 11321 and 11340, Business and Professions Code. Reference: Sections 11313, 11314 and 11340, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

§ 3732. Restricted or Conditional License.

A restricted or conditional license issued pursuant to this chapter shall contain the restriction or condition until it is lifted, in writing, by the Director.

(a) In order to have the condition or restriction removed, the licensee shall submit to the Office a letter requesting the condition or restriction be lifted, along with appropriate evidence of compliance with any restriction or condition, and the appropriate fee as provided in Section 3582.

(b) The Director may, without hearing, issue an order suspending a licensee's right to further exercise any privileges granted under a restricted or conditional license pending final determination made after formal hearing, except, that a restricted or conditional license requiring completion of educational requirements shall be automatically suspended upon the licensee's failure to comply with the condition or restriction. The suspension shall not be lifted until the suspended licensee has submitted the required evidence of course completion with the appropriate fees as provided in Section 3582, and the Director has given written notice to the licensee of the lifting of the suspension.

NOTE: Authority cited: Sections 11313, 11314, 11320 and 11321, Business and Professions Code. Reference: Sections 11313, 11314 and 11320, Business and Professions Code.

HISTORY

1. New section filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44).

Article 13. Investigations and Hearings

§ 3741. Consent Determinations.

(a) At any time after the Director has served a Notice of Conference, or after the Director has served a Statement of Issues or an Accusation against an applicant or licensed appraiser and a Notice of Defense has been filed, the applicant or licensee and the Office may enter into a settlement upon terms which include a plan for abatement of the violation or rehabilitation or re-qualification of the applicant or licensed appraiser within a specified time, consistent with other provisions of law and regulations.

(b) If the Director determines that the public interest would not be prejudiced by a settlement of the disputed facts by the issuance of a restricted license he/she may order such issuance upon such lawful terms and conditions as he/she may deem appropriate to impose and which the applicant or licensed appraiser may deem appropriate to accept.

NOTE: Authority cited: Sections 11314 and 11340, Business and Professions Code. Reference: Section 11314, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 3557 to new section 3741 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 23.

Article 14. Personal Information

§ 3761. Personal Information, Access.

(a) Unless otherwise exempted by law, every person or his or her designated representative upon reasonable notice, identification and payment of copy fees shall have the following rights to inspect Office records containing personal information about himself or herself:

(1) To know if the OREA maintains any record about him or her;

(2) To inspect and to obtain a readable copy of such record if it exists;

(3) To request correction or amendment of such record if it is inaccurate or incomplete;

(4) To know if such record has been disclosed to any other person or agency, and the times and conditions of such disclosure;

(5) To be heard by the Director if any of these rights are abridged or denied;

(6) If the Director denies a request for correction or amendment of a personal record, to receive a concise statement of the reasons for the Director's denial, and to file a statement of reasonable length setting forth the reasons for the disagreement; and to have copies of such reasons and statement of disagreement made available by OREA to any persons or agency to whom the disputed record has been or is disclosed.

(b) All personal records about persons regulated by the Office are maintained at its office. Requests for access to such records should be addressed as follows:

OFFICE OF REAL ESTATE APPRAISERS
1102 Q STREET, SUITE 4100
SACRAMENTO, CA 95814
(916) 552-9000

(c) The rights specified in (a)(1) through (6) are not exclusive, and do not foreclose rights which may be available under other provisions of law.

(d) Inquiries relating to whether or not licenses are current and in good standing are excluded from the requirement contained in (a)(4) above.

NOTE: Authority cited: Sections 11313 and 11314, Business and Professions Code. Reference: Section 1798.30, Civil Code.

HISTORY

1. Renumbering of former article 14 to new article 15, new article 14 (section 3761), and renumbering and amendment of former section 3558 to new section 3761 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 94, No. 26.
2. Amendment of subsection (b) filed 6-15-2000; operative 7-15-2000 (Register 2000, No. 24).
3. Amendment of subsection (b) filed 8-8-2006; operative 9-7-2006 (Register 2006, No. 32).

Article 15. Office of Real Estate Appraisers—Conflict of Interest Code

It having been found, pursuant to Government Code section 11344, that the printing of regulations constituting the Conflict of Interest Code is impractical and these regulations being of limited and particular application are not published in full in the California Code of Regulations. The Regulations are available to the public for review or purchase at cost at the following locations:

OFFICE OF REAL ESTATE APPRAISERS
1755 CREEKSIDE OAKS DRIVE, SUITE 190
SACRAMENTO, CA 95833

FAIR POLITICAL PRACTICES COMMISSION
1100 "K" STREET
SACRAMENTO, CA 95814

ARCHIVES
SECRETARY OF STATE
1020 "O" STREET
SACRAMENTO, CA 95814

The conflict of interest code is designated as article 15 of chapter 6.5 of title 10 of the California Code of Regulations, and consists of sections numbered and titled as follows:

Article 15. Office of Real Estate Appraisers—Conflict of Interest Code

Section
3780 General Provisions
Appendix A
Appendix B

NOTE: Authority cited: Section 87300, Government Code. Reference: Sections 87300–87302 and 87306, Government Code.

HISTORY

1. Renumbering of former article 14 to new article 15, and renumbering and amendment of former section 3559 to new section 3780 filed 11-1-96; operative 11-1-96 pursuant to Government Code section 11343.4(d) (Register 96, No. 44). For prior history, see Register 95, No. 49.
2. Amendment reflecting new address for the Office of Real Estate Appraisers filed 6-15-2000; operative 7-15-2000 (Register 2000, No. 24).

* * *

Barclays Official

CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 6.49. Los Angeles Revitalization Zone Designation

Vol. 14

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Chapter 6.49. Los Angeles Revitalization Zone Designation

HISTORY

1. Chapter 6.49 (sections 3990–3992) repealed by operation of Government Code section 11346.1(g) (Register 93, No. 12). For prior history, see Register 92, No. 44.

* * *

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 6.50. Personal Responsibility and Work Opportunity Reconciliation

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§ 4005. Limitations on Public Benefits for Aliens.

Chapter 6.50. Personal Responsibility and Work Opportunity Reconciliation

§ 4001. Limitations on Public Benefits for Aliens.

(a) All eligibility requirements contained herein shall be applied without regard to the race, creed, color, gender, religion, national origin, or disability of the individual applying for the public benefit.

(b) Pursuant to Section 411 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. No. 104–193 (PRWORA)), (8 U.S.C. sec. 1621), and notwithstanding any other provision of this division, aliens who are not qualified aliens, nonimmigrant aliens under the Immigration and Nationality Act (INA) (8 U.S.C. sec. 1101 et seq.), or aliens paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. sec. 1182(d)(5)) for less than one year, are not eligible to receive loans under the Direct Farm Loan Program (Corporations Code 14070(e)), the Old Growth Diversification Loan Program (Government Code section 15330(b) and 16 U.S.C. sec. 21201 et seq.), and the Remove Underground Storage Tank Program (RUST) (Government Code secs. 15399.12–15399.13), except as provided in 8 USCS 1621(c)(2).

(c) A qualified alien is an alien who, at the time he or she applies for, receives, or attempts to receive a public benefit, is, under Section 431(b) and (c) of the PRWORA (8 U.S.C. sec. 1641(b) and (c) except as provided in any of the following:

(1) An alien who is lawfully admitted for permanent residence under the INA (8 U.S.C. sec. 1101 et seq.).

(2) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. sec. 1158).

(3) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. sec. 1157).

(4) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. sec. 1182(d)(5)) for a period of at least one year.

(5) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. sec. 1253(h)) (as in effect immediately before the effective date of Section 307 of division C of Public Law 104–208) or Section 241(b)(3) of such Act (8 U.S.C. sec. 1251(b)(3)) (as amended by Section 305(a) of division C of Public Law 104–208).

(6) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980. (8 U.S.C. sec. 1153(a)(7)) (See editorial note under 8 U.S.C. sec. 1101, "Effective Date of 1980 Amendment.")

(7) An alien who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (8 U.S.C. sec. 1522 note)).

(8) An alien who meets all of the conditions of subparagraphs (A), (B), (C), and (D) below:

(A) The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Trade and Commerce Agency. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien to lose his or her job or to earn less or to require the alien to leave his or her job for safety reasons.

5. The benefits are needed because the alien requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

(C) The alien has a petition that has been approved or has a petition pending which sets forth a prima facie case for:

1. status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. sec. 1154(a)(1)(A)(ii), (iii) or (iv)),

2. classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. sec. 1154(a)(1)(B)(ii) or (iii)),

3. suspension of deportation and adjustment of status pursuant to section 244(a)(3) of the INA (8 U.S.C. sec. 1254 as in effect prior to April 1, 1997 [Pub.L. 104–208, sec. 501 (effective Sept. 30, 1996, pursuant to sec. 591); Pub.L. 104–208, sec. 304 (effective April 1, 1997, pursuant to sec. 309); Pub.L. 105–33, sec. 5581 (effective pursuant to sec. 5582)] (incorrectly codified as "cancellation of removal under section 240A of such Act [8 USCS Sec. 1229b] (as in effect prior to April 1, 1997)."

4. status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. sec. 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 USC section 1154(a)(1)(B)(i), or

5. cancellation of removal pursuant to Section 204A(b)(2) of the INA (8 U.S.C. section 1229b(b)(2)).

(D) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(9) An alien who meets all of the conditions of subparagraphs (A), (B), (C), (D) and (E) below:

(A) The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) The alien did not actively participate in such battery or cruelty.

(C) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Trade

and Commerce Agency. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien's child to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien's child from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's child's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien's child to lose his or her job or to earn less or to require the alien's child to leave his or her job for safety reasons.

5. The benefits are needed because the alien's child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's child's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien's child and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien's child had when living with the abuser.

(D) The alien meets the requirements of subsection (c)(8)(C) above.

(E) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(10) An alien child who meets all of the conditions of subparagraphs (A), (B), and (C) below:

(A) The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to, being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Trade and Commerce Agency. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien child's parent to become self– sufficient following the separation from the abuser.

2. The benefits are needed to enable the alien child's parent to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien child's parent from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien child's parent's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien child's parent to lose his or her job or to earn less or to require the alien child's parent to leave his or her job for safety reasons.

5. The benefits are needed because the alien child's parent requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien child's parent's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien child's parent and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien child's parent had when living with the abuser.

(C) The alien child meets the requirements of subsection (c)(8)(C) above.

(d) For purposes of this section, "nonimmigrant" is defined the same as in Section 101(a)(15) of the INA (8 U.S.C. sec. 1101(a)(15)).

(e) For purposes of establishing eligibility for public benefits under the Direct Farm Loan Program (Corporation Code section 14070(e), the Old Growth Diversification Loan Program (Government Code section 15330(b) and 16 U.S.C. section 21201 et seq.), and the Remove Underground Storage Tank Program (RUST) (Government Code sections 15399.12–15399.13), all of the following must be met:

(1) The applicant must declare himself or herself to be a citizen of the United States, a qualified alien under subsection (c), a nonimmigrant alien under subsection (d), or an alien paroled into the United States for less than one year under Section 212(d)(5) of the INA (8 U.S.C. sec. 1182(d)(5)). The applicant shall declare that status through use of the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits" Form, which form is identified as CTCA Form 046, June 17, 1998 edition, and hereby incorporated by reference.

(2) The applicant must present documents of a type acceptable to the Immigration and Naturalization Service (INS) which serve as reasonable evidence of the applicant's declared status. A fee receipt from the INS for replacement of a lost, stolen, or unreadable INS document is reasonable evidence of the alien's declared status.

(3) The applicant must complete and sign the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits," Form.

(4) Where the documents presented do not on their face reasonably appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the documents shall be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The Trade and Commerce Agency shall request verification from the INS by filing INS Form G–845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant shall be referred to the local INS office to obtain documentation.

(5) The type of documentation referred to the INS for verification pursuant to INS Form G–845 shall include the following:

(A) The document presented indicates immigration status but does not include an alien registration or alien admission number.

(B) The document is suspected to be counterfeit or to have been altered.

(C) The document includes an alien registration number in the A60 000 000 (not yet issued) or A80 000 000 (illegal border crossing) series.

(D) The document is one of the following: an INS Form I–181b notification letter issued in connection with an INS Form I–181 Memorandum of Creation of Record of Permanent Residence, an Arrival–Departure Record (INS Form I–94) or a foreign passport stamped "PROCESSED FOR I–551, TEMPORARY EVIDENCE OF LAWFUL PERMANENT RESIDENCE" that INS issued more than one year before the date of application for a loan under the Direct Farm Loan Program (Corporation Code sec. 14070(e)), the Old Growth Diversification Loan Program (Government Code section 15330(b) and 16 U.S.C. sec. 21201 et seq.), and the Remove Underground Storage Tank Program (RUST) (Government Code sections 15399.12–15399.13).

(6) If the INS advises that the applicant has citizenship status or immigration status which makes him or her a qualified alien, a nonimmigrant or alien paroled for less than one year under section 212(d)(5) of the INA, the INS verification shall be accepted. If the INS advises that it cannot verify that the applicant has citizenship status or an immigration status that makes him or her a qualified alien, a nonimmigrant or an alien paroled for less than one year under section 212(d)(5) of the INA, benefits shall be denied and the applicant notified pursuant to the regular procedures of the Direct Farm Loan Program (Corporation Code sec. 14070(e), the Old Growth Diversification Loan Program (Government Code section 15330(b) and 16 U.S.C. sec. 21201 et seq.), and the Remove Underground Storage Tank Program (RUST) (Government Code sections 15399.12–15399.13), as may be applicable, of his or her rights to appeal the denial of benefits.

(f) Pursuant to Section 434 of the PRWORA (8 U.S.C. sec. 1644), where the Trade and Commerce Agency reasonably believes that an alien is unlawfully in the State based on the failure of the alien to provide reasonable evidence of the alien's declared status, after an opportunity to do so, said alien shall be reported to the Immigration and Naturalization Service.

(g) Provided that the alien has completed and signed the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits," (CTCA Form 046, June 17, 1998 edition) under penalty of perjury, eligibility for the Direct Farm Loan Program (Corporation Code sec. 14070(e)), the Old Growth Diversification Loan Program (Government Code 15330(b)) and (16 U.S.C. sec. 21201 et seq.), and the Remove Underground Storage Tank Program (RUST) (Government Code sections 15399.12–15399.13), shall not be delayed, denied, reduced or terminated while the status of the alien is verified.

(h) Pursuant to Section 432(d) of the PRWORA (8 U.S.C. sec. 1642(d)), a nonprofit charitable organization that provides federal, state or local public benefits shall not be required to determine, verify, or otherwise require proof of eligibility of any applicant or beneficiary with respect to his or her immigration status or alienage.

(i) The Secretary shall notify the applicant by certified letter that the applicant is ineligible for a public benefit pursuant to subsections (b) and (e), or that the public benefit is terminated or suspended pursuant to subsections (b) and (e). The letter shall include the following:

(1) The name and address of the applicant.

(2) The reason for the ineligibility and/or termination or suspension of the public benefit.

(3) A copy of Section 4001, Title 10, California Code of Regulations.

(4) A statement informing the applicant that he or she has the right to request a hearing to contest the Secretary's decision pursuant to the procedure described in subsection (j).

(j) An applicant who has been denied a loan in any of the above enumerated programs based solely upon the applicant's immigration status, may request a hearing to appeal that decision. The request for a hearing shall be in writing and shall be submitted to the Secretary no later than fifteen (15) calendar days following the mailing of the subsection (i) letter. The hearing shall be conducted as follows:

(1) The applicant shall have the right to be represented by legal counsel at the hearing.

(2) The proceedings of the hearing shall be recorded by an electronic tape recording system.

(3) At the hearing the Agency's representative and the applicant may make statements and submit evidence regarding the applicant's eligibility.

(4) The Secretary or his or her designee may ask the Agency's representative and the applicant questions regarding the applicant's eligibility.

(5) At or within 10 days following the conclusion of the hearing, the Secretary or his or her designee shall make a decision which contains findings or reasons for the decision.

(6) The Agency shall provide the applicant, by certified mail, a copy of the Secretary's or his or her designee's decision.

(7) The applicant may request judicial review by filing a writ of mandate in accordance with provisions of the Code of Civil Procedure.

NOTE: Authority cited: Section 14024, Corporations Code; Sections 15330(b) and 15399.16, Government Code; and 16 U.S.C. Section 21201 et seq. Reference: Sections 15330(b) and 15399.12–15399.13, Government Code; Section 14070(e), Corporations Code; and 8 U.S.C. Sections 1621, 1641 and 1642.

HISTORY

1. New chapter 6.50 (section 4001) and section filed 6–25–98 as an emergency; operative 6–25–98 (Register 98, No. 26). A Certificate of Compliance must be transmitted to OAL by 10–23–98 or emergency language will be repealed by operation of law on the following day. For prior history of chapter 6.50 (sections 4000–4009), see Register 92, No. 39.
2. Repealer of chapter 6.50 and section by operation of Government Code section 11346.1(g) (Register 99, No. 38).
3. New chapter 6.50 (section 4001) and section filed 9–14–99; operative 10–14–99 (Register 99, No. 38).

§ 4005. Limitations on Public Benefits for Aliens.

(a) All eligibility requirements contained herein shall be applied without regard to the race, creed, color, gender, religion, disability, or national origin of the individual applying for the public benefit.

(b) Pursuant to Section 411 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. No. 104–193 (PRWORA)), (8 U.S.C. sec. 1621), and notwithstanding any other provision of this division, aliens who are not qualified aliens, nonimmigrant aliens under the Immigration and Nationality Act (INA) (8 U.S.C. sec. 1101 et seq.), or aliens paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. sec. 1182(d)(5)) for less than one year, are not eligible to receive loans under the Fishing Fleet Loan program (Fish and Game Code section 9100), except as provided in 8 USCS 1621(c)(2).

(c) A qualified alien is an alien who, at the time he or she applies for, receives, or attempts to receive a public benefit, is, under Section 431(b) and (c) of the PRWORA (8 U.S.C. sections 1641(b) and (c), any of the following:

(1) An alien who is lawfully admitted for permanent residence under the INA (8 U.S.C. sec. 1101 et seq.).

(2) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. sec. 1158).

(3) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. sec. 1157).

(4) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. sec. 1182(d)(5)) for a period of at least one year.

(5) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Sec. 1253(h)) (as in effect immediately before the effective date of Section 307 of division C of Public Law 104–208) or Section 241(b)(3) of such Act (8 U.S.C. sec. 1251(b)(3)) (as amended by Section 305(a) of division C of Public Law 104–208).

(6) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980. (8 U.S.C. sec. 1153(a)(7)) (See editorial note under 8 U.S.C. sec. 1101, "Effective Date of 1980 Amendment.")

(7) An alien who is a Cuban or Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 (8 U.S.C. sec. 1522 note)).

(8) An alien who meets all of the conditions of subparagraphs (A), (B), (C), and (D) below:

(A) The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or

parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Office of Planning and Research. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien to lose his or her job or to earn less or to require the alien to leave his or her job for safety reasons.

5. The benefits are needed because the alien requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien had when living with the abuser.

(C) The alien has a petition that has been approved or has a petition pending which sets forth a prima facie case for:

1. status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. section. 1154(a)(1)(A)(ii), (iii) or (iv)),

2. classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. section 1154(a)(1)(B)(ii) or (iii)),

3. suspension of deportation and adjustment of status pursuant to section 244(a)(3) of the INA (8 U.S.C. sec. 1254 as in effect prior to April 1, 1997 [Pub.L. 104–208, sec. 501 (effective Sept. 30, 1996, pursuant to sec. 591); Pub.L. 104–208, sec. 304 (effective April 1, 1997, pursuant to sec. 309); Pub.L. 105–33, sec. 5581 (effective pursuant to sec. 5582)] (incorrectly codified as "cancellation of removal under section 240A of such Act [8 USCS Sec. 1229b] (as in effect prior to April 1, 1997)."

4. status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. s 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 USC section 1154(a)(1)(B)(i), or

5. cancellation of removal pursuant to Section 204A(b)(2) of the INA (8 U.S.C. section 1229b(b)(2)).

(D) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(9) An alien who meets all of the conditions of subparagraphs (A), (B), (C), (D) and (E) below:

(A) The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered as acts of violence.

(B) The alien did not actively participate in such battery or cruelty.

(C) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Office of Planning and Research. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien's child to become self–sufficient following separation from the abuser.

2. The benefits are needed to enable the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien's child from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien's child's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien's child to lose his or her job or to earn less or to require the alien's child to leave his or her job for safety reasons.

5. The benefits are needed because the alien's child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's child's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien's child and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien's child had when living with the abuser.

(D) The alien meets the requirements of subsection (c)(8)(C) above.

(E) For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(10) An alien child who meets all of the conditions of subparagraphs (A), (B), and (C) below:

(A) The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty. For purposes of this subsection, the term "battered or subjected to extreme cruelty" includes, but is not limited to, being the victim of any act or threatened act of violence including any forceful detention, which results or threatens to result in physical or mental injury. Rape, molestation, incest (if the victim is a minor), or forced prostitution shall be considered acts of violence.

(B) There is a substantial connection between such battery or cruelty and the need for the benefits to be provided in the opinion of the Office of Planning and Research. For purposes of this subsection, the following circumstances demonstrate a substantial connection between the battery or cruelty and the need for the benefits to be provided:

1. The benefits are needed to enable the alien child's parent to become self– sufficient following the separation from the abuser.

2. The benefits are needed to enable the alien child's parent to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien child's parent from the abuser.

3. The benefits are needed due to a loss of financial support resulting from the alien child's parent's separation from the abuser.

4. The benefits are needed because the battery or cruelty, separation from the abuser, or work absences or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto (including resulting child support, child custody, and divorce actions) cause the alien child's parent to lose his or her job or to earn less or to require the alien child's parent to leave his or her job for safety reasons.

5. The benefits are needed because the alien child's parent requires medical attention or mental health counseling, or has become disabled, as a result of the battery or extreme cruelty.

6. The benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien child's parent's ability to care for his or her children (e.g., inability to house, feed, or clothe children or to put children into day care for fear of being found by the abuser).

7. The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser.

8. The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien child's parent and/or to care for any resulting children.

9. Where medical coverage and/or health care services are needed to replace medical coverage or health care services the alien child's parent had when living with the abuser.

(C) The alien child meets the requirements of subsection (c)(8)(C) above.

(d) For purposes of this section, "nonimmigrant" is defined the same as in Section 101(a)(15) of the INA (8 U.S.C. sec. 1101(a)(15)).

(e) For purposes of establishing eligibility for public benefits under the Fishing Fleet Loan Program (Fish and Game Code section 9100), all of the following must be met:

(1) The applicant must declare himself or herself to be a citizen of the United States a qualified alien under subsection (c), a nonimmigrant alien under subsection (d), or an alien paroled into the United States for less than one year under Section 212(d)(5) of the INA (8 U.S.C. sec. 1182(d)(5)). The applicant shall declare that status through use of the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits" Form, which form is identified as CTCA Form 046, June 17, 1998 edition, and hereby incorporated by reference.

(2) The applicant must present documents of a type acceptable to the Immigration and Naturalization Service (INS) which serve as reasonable evidence of the applicant's declared status. A fee receipt from the INS for replacement of a lost, stolen, or unreadable INS document is reasonable evidence of the alien's declared status.

(3) The applicant must complete and sign the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits," Form.

(4) Where the documents presented do not on their face reasonably appear to be genuine or to relate to the individual presenting them, the government entity that originally issued the documents shall be contacted for verification. With regard to naturalized citizens and derivative citizens presenting certificates of citizenship and aliens, the INS is the appropriate government entity to contact for verification. The Office of Planning Research shall request verification from the INS by filing INS Form G–845 with copies of the pertinent documents provided by the applicant with the local INS office. If the applicant has lost his or her original documents or presents expired documents or is unable to present any documentation evidencing his or her immigration status, the applicant shall be referred to the local INS office to obtain documentation.

(5) The type of documentation referred to the INS for verification pursuant to INS Form G–845 shall include the following:

(A) The document presented indicates immigration status but does not include an alien registration or alien admission number.

(B) The document is suspected to be counterfeit or to have been altered.

(C) The document includes an alien registration number in the A60 000 000 (not yet issued) or A80 000 000 (illegal border crossing) series.

(D) The document is one of the following: an INS Form I–181b notification letter issued in connection with an INS Form I–181 Memorandum of Creation of Record of Permanent Residence, an Arrival–Departure Record (INS Form I–94) or a foreign passport stamped "PROCESSED FOR I–551, TEMPORARY EVIDENCE OF LAWFUL PERMANENT RESIDENCE" that INS issued more than one year before the date of application for a loan under the Fishing Fleet Loan program (Fish and Game Code section 9100).

(6) If the INS advises that the applicant has citizenship status or immigration status which makes him or her a qualified alien, a nonimmigrant or alien paroled for less than one year under section 212(d)(5) of the INA, the INS verification shall be accepted. If the INS advises that it cannot verify that the applicant has citizenship status or an immigration status that makes him or her a qualified alien, a nonimmigrant or an alien paroled for less than one year under section 212(d)(5) of the INA, benefits shall be denied and the applicant notified pursuant to the regular procedures of the Fishing Fleet Loan program (Fish and Game code section 9100) as may be applicable, of his or her rights to appeal the denial of benefits.

(f) Pursuant to Section 434 of the PRWORA (8 U.S.C. sec. 1644), where the Office of Planning and Research reasonably believes that an alien is unlawfully in the State based on the failure of the alien to provide reasonable evidence of the alien's declared status, after an opportunity to do so, said alien shall be reported to the Immigration and Naturalization Service.

(g) Provided that the alien has completed and signed the "Statement of Citizenship, Alienage, and Immigration Status for State Public Benefits," Form under penalty of perjury, eligibility for the Fishing Fleet Loan program (Fish and Game Code 9100), shall not be delayed, denied, reduced or terminated while the status of the alien is verified.

(h) Pursuant to Section 432(d) of the PRWORA (8 U.S.C. sec. 1642(d)), a nonprofit charitable organization that provides federal, state or local public benefits shall not be required to determine, verify, or otherwise require proof of eligibility of any applicant or beneficiary with respect to his or her immigration status or alienage.

(i) The Director shall notify the applicant by certified letter that the applicant is ineligible for a public benefit pursuant to subsections (b) and (e), or that the public benefit is terminated or suspended pursuant to subsections (b) and (e). The letter shall include the following:

(1) The name and address of the applicant.

(2) The reason for the ineligibility and/or termination or suspension of the public benefit.

(3) A copy of Section 4001, Title 10, California Code of Regulations.

(4) A statement informing the applicant that he or she has the right to request a hearing to contest the Director's decision pursuant to the procedure described in subsection (j).

(j) An applicant who has been denied a loan in any of the above enumerated programs based solely on the applicant's immigration status, may request a hearing to appeal that decision. The request for a hearing shall be in writing and shall be submitted to the Director of the Office of Planning and Research no later than fifteen (15) calendar days following the mailing of the subsection (i) letter. The hearing shall be conducted as follows:

(1) The applicant shall have the right to be represented by legal counsel at the hearing.

(2) The proceedings of the hearing shall be recorded by an electronic tape recording system.

(3) At the hearing the Office's representative and the applicant may make statements and submit evidence regarding the applicant's eligibility.

(4) The Director or his or her designee may ask the Office's representative and the applicant questions regarding the applicant's eligibility.

(5) At or within 10 days following the conclusion of the hearing, the Director or his or her designee shall make a decision which contains findings or reasons for the decision.

(6) The Office shall provide the applicant, by certified mail, a copy of the Director's or his or her designee's decision.

(7) The applicant may request judicial review by filing a writ of mandate in accordance with provisions of the Code of Civil Procedure.

NOTE: Authority cited: Section 14024, Corporations Code; Sections 15330(b) and 15399.16, Government Code; and 16 U.S.C. Section 21201 et seq. Reference: Sections 15330(b) and 15399.12–15399.13, Government Code; Section 14070(e), Corporations Code; and 8 U.S.C. Sections 1621, 1641 and 1642.

HISTORY

1. New section filed 10–13–99; operative 11–12–99 (Register 99, No. 42). For prior history see chapter 6.51, section 4005.

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Title 10. Investment

Chapter 6.51. Business, Transportation and Housing Agency: Emergency Small Business and Farm Enterprise Guarantees

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Chapter 6.51. Business, Transportation and Housing Agency: Emergency Small Business and Farm Enterprise Guarantees

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Chapter 6.51. Business, Transportation and Housing Agency: Emergency Small Business and Farm Enterprise Guarantees

Article 1. General Provisions

§ 4010. Definitions.

In addition to the definitions contained in Corporations Code section 14010 and section 5000 of Title 10 of the California Code of Regulations, the following supplemental definitions shall govern the construction of this chapter:

(a) "Agricultural Enterprise" means a business engaged in the production of food fiber, ranching and raising of livestock, agriculture, or other similar agriculture–related industries, other than farming.

(b) "Application" means (1) for an Applicant for a Small Business Loan, the application for a Federal Disaster Loan, and (2) for an Applicant for an Enterprise Loan, the loan application submitted to the Lender.

(c) "Borrower" means, for an Article 2 Loan, a Small Business that has received a Loan; for an Article 3 Loan, a Farm Enterprise that has received a Loan.

(d) "Creditworthy" means that as a result of the Loan the Borrower will, for the reasonably foreseeable future, continue or resume operations in the same business enterprise disrupted by the Disaster.

(e) "Default" means failure by the Borrower to pay when due any interest or principal payment as provided in the Loan Agreement.

(f) "Demand" means a request for payment by a Lender pursuant to section 4013.

(g) "Demand letter" means a letter containing a Demand for payment of the guaranteed portion of Loan interest and principal, delivered pursuant to section 4013(b).

(h) "Disaster" and "Disaster Area" mean, for a Small Business Loan, a major disaster, and the geographic area of that disaster, respectively, as determined under the Disaster Relief and Emergency Assistance Act, 42 U.S.C.A. section 5121 et seq. of the Small Business Act, 15 U.S.C.A. section 636 and for a Farm Enterprise Loan, an emergency pursuant to Government Code Section 8558, declared by the Governor.

(i) "Economic injury" means an economic loss resulting in the inability of a business, as a direct result of a Disaster, to meet its obligations as they mature and to pay its ordinary and necessary operating expenses, including production losses.

(j) "Federal Disaster Loan" means a Small Business Administration Physical Disaster Loan or Economic Injury Disaster Loan made pursuant to 13 C.F.R. Section 123.

(k) "Farm Enterprise" means an Agricultural Enterprise, Nursery or Small Farm.

(*l*) "Guarantee" means a written agreement, made in accordance with chapter 6.51 of Title 10 of the California Code of Regulations, to guarantee the repayment of a portion of a Loan.

(m) "Lender" means a commercial lending institution which is a bank, savings and loan institution, institution of the Farm Credit System, as specified in 12 United States Code Section 2002 or credit union licensed to do business in California.

(n) "Lender Certification" means a written statement by Lender certifying that (1) the Loan would not be made without the Guarantee, and (2) the Lender will not charge Loan fees or charges other than those charged for similar Loans.

(o) "Loan" means a Loan made pursuant to a Loan Agreement.

(p) "Loan Agreement" means an agreement for Loan entered into between a Lender and Borrower, which is guaranteed pursuant to section 4012.

(q) "Nursery" means a Small Business primarily engaged in the wholesale or retail selling of plants.

(r) "Physical Damage" means a real or personal property damaged or lost, including structural losses, as a direct result of a Disaster.

(s) "Prime" means the Lender's publicly announced prime rate.

(t) "Production Losses" means a reduction in normal production of one or more of the following, directly attributable to the Disaster:

(1) yield per acre;

(2) quality of crops produced;

(3) quantity and/or quality of livestock products produced per animal unit; and

(4) weight gain and/or natural increase in numbers of livestock units.

(u) "Security" means a lien on any equipment purchased with Loan proceeds, and to the extent required by a Corporation, a first beneficial interest in the life insurance policies of Borrower management personnel, and security interests in Borrower's real or personal property.

(v) "Small Farms" means a farm which:

(1) Provides agricultural commodities for sale in sufficient quantities so that it is recognized in the community as a farm rather than a rural residence.

(2) Provides enough agricultural income by itself, including rented land, or together with any other dependable income, to enable the Borrower to:

(A) pay necessary family and operating expenses;

(B) maintain essential chattel and real property; and

(C) pay debts*.

(3) Is managed by:

(A) the Borrower when the Loan is made to an individual; or

(B) the members, stockholders, partners or joint operators responsible for operating the farm when a Loan is made to a cooperative, corporation, partnership or joint operation.

(4) Has substantial amount of the labor requirements for the farm and non–farm enterprise provided by:

(A) the Borrower and family members for a Loan made to an individual; or

(B) the members, stockholders, partners or joint operators responsible for operating the farm, along with the families of these individuals, if a Loan is made to a cooperative, corporation, partnership, or joint operation.

(5) May use a reasonable amount of full–time hired labor and seasonable labor during peak loan periods.

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*For the purposes of calculating subsection (2), a farmer shall be authorized to calculate the projected income reasonably expected from an orchard when the trees are fully producing.

NOTE: Authority cited: Section 14075 (b), Corporations Code. Reference: Section 14075 (a), Corporations Code; and Section 8684.2, Government Code.

HISTORY

1. New section filed 12–8–89 as an emergency; operative 12–8–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4–9–90.
2. Amendment of subsections (b), (h), (n) and (q) filed 12–22–89 as an emergency; operative 12–22–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 4–23–90.
3. Certificate of Compliance as to 12–8–89 and 12–22–89 orders including nonsubstantive amendments transmitted to OAL 4–6–90 and filed 5–7–90 (Register 90, No. 25).
4. Amendment filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
5. Amendment refiled 4–9–91 including new amendment of subsections (a), (m) and (v) as an emergency; operative 4–9–91 (Register 91, No. 25). A Certificate of Compliance must be transmitted to OAL by 8–7–91 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of printing error removing erroneous former HISTORY 5. (Register 91, No. 25).
7. Editorial correction of subsections (p) and (v)(4)(B) (Register 91, No. 32).
8. Change without regulatory effect amending section filed 9–3–91 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 3).
9. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.

10. Renumbering of former section 4010 to section 4610 and new section 4010 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
11. Change without regulatory effect amending chapter heading filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
12. Amendment of chapter heading and section filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
13. Editorial correction of HISTORY 12 (Register 2005, No. 27).
14. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 4011. Guarantee Procedures.

The potential borrower applying for a Guarantee shall provide a copy of the Application, together with any other information required by these regulations, to the Corporation for processing in accordance with the following procedures:

(a) No Guarantee shall be executed by a Corporation until the proposed guarantee has been reviewed by the Corporation's loan committee, approved by its board of directors and the Corporation receives a Lender Certification.

(b) Upon completion of the review and approval specified in subsection (a), the Corporation shall issue a commitment to guarantee and an executed Guarantee to the Lender.

(c) In the event that a Guarantee is issued to the Lender without first complying with the requirements of subsection (a), and the Lender relies upon the Guarantee in making the Loan, the failure by the Corporation to so comply shall not constitute a defense on the part of either the Agency or Corporation to paying a Demand for payment made pursuant to section 4013.

(d) In any case where funds are disbursed to a Lender pursuant to a Demand and the Corporation has failed to comply with subsection (a), the Agency shall immediately exercise all available legal remedies to recover from the Corporation the funds disbursed pursuant to the Demand.

NOTE: Authority cited: Section 14075 (b), Corporations Code. Reference: Section 14075 (a), Corporations Code and Section 8684.2, Government Code.

HISTORY

1. New section filed 12–8–89 as an emergency; operative 12–8–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4–9–90.
2. Amendment of subsections filed 12–22–89 as an emergency; operative 12–22–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 4–23–90.
3. Certificate of Compliance as to 12–8–89 and 12–22–89 orders including nonsubstantive amendments transmitted to OAL 4–6–90 and filed 5–7–90 (Register 90, No. 25).
4. Amendment filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
5. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
6. Renumbering of former section 4011 to section 4611 and new section 4011 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
7. Amendment of subsections (c) and (d) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
8. Editorial correction of HISTORY 7 (Register 2005, No. 27).
9. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 4012. Loan Terms.

The terms and conditions of a Loan shall include all of the following:

(a) An interest rate not to exceed one percent greater than the net interest cost on the Bonds issued in connection with a Loan. As used in this subsection, "net interest cost" is determined by dividing the total interest payments for the Bonds (reduced by any premium or accrued interest and increased by any discount) by the product of the issue price (which is the par amount of the Bonds less any discount and increased by any premium) and the weighted maturity of the issue (which is the average maturity of the issue weighted to reflect the dollar amount of each particular maturity).

(b) A maximum Loan amount no greater than seven hundred and fifty thousand dollars ($750,000).

(c) A minimum Loan amount no less than ten thousand dollars ($10,000).

(d) A Loan term not to exceed eight (8) years; provided that no Loan term shall exceed the final maturity of the Bonds.

(e) The Loan is fully amortized.

(f) A Loan fee of two percent (2%) of the amount of the Loan or five hundred dollars ($500), whichever is greater, to be paid to the Authority.

(g) Late charges in the event of a default.

(h) Any other provision agreed to by the parties.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. New section filed 12–8–89 as an emergency; operative 12–8–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4–9–90.
2. Amendment of subsections (b)(1)(A) and (b)(3) filed 12–22–89 as an emergency; operative 12–22–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 4–23–90.
3. Certificate of Compliance as to 12–8–89 and 12–22–89 orders transmitted to OAL 4–6–90 and filed 5–7–90 (Register 90, No. 25).
4. Renumbering and amendment of former section 4012 to section 4015 filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
5. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.

§ 4013. Demand Procedures.

(a) The Lender shall be authorized to make a Demand upon the Corporation executing the Guarantee for repayment of the unpaid Loan principal and interest pursuant to the Guarantee, upon compliance with the following:

(1) (A) Borrower is a minimum of ninety (90) calendar days in arrears on payment either of Loan interest or principal,

(B) a petition in bankruptcy has been filed by or against the Borrower, or

(C) the Loan has matured and any portion remains unpaid.

(2) In the case of a Demand pursuant to subsection (a)(1)(A), Lender has delivered to both the Borrower and Corporation a minimum of two (2) letters subsequent to the Default, at least thirty (30) calendar days apart, explaining the Default, the need for Borrower to remedy the Default, and the consequences for failure to remedy the Default. This requirement shall not apply if Borrower is in bankruptcy or if the Loan has matured.

(b) The Lender delivers to the Corporation executing the Guarantee a Demand Letter requesting immediate payment of the guaranteed portion of Loan interest and principal, and documenting compliance with subsection (a)(1), and where applicable, subsection (a)(2).

(c) Upon receipt of the Demand Letter, the Corporation, or Corporation's contractor, which may be the California Department of Financial Institutions, shall conduct an investigation to determine whether the Lender has complied with the terms of the Guarantee. No later than thirty (30) calendar days from the date the Corporation receives the Demand Letter, the Corporation shall do one of the following:

(1) Deliver to the Agency a Request for payment on the Demand, summarizing the results of the investigation, with a copy simultaneously delivered to the Lender, or

(2) Deliver to the Lender, with a copy simultaneously delivered to the Agency, a refusal to make payment pursuant to the Demand, and detailing the reasons for refusal.

(d) Upon receipt of the request for payment described in subsection (c)(1), within ten (10) calendar days from the date the Agency receives the request for payment, the Agency shall do one of the following and simultaneously inform the Lender of such action:

(1) Deliver or cause to be delivered to the Corporation a check in an amount not to exceed the amount contained in the Demand Letter, made payable to the Lender; or

(2) Deliver or cause to be delivered a denial of request of payment to the Corporation based upon fraud or gross negligence on the part of the Lender known to the Agency.

(3) Deliver or cause to be delivered to the Corporation a statement that the investigation was incomplete, and requiring the Corporation to complete the investigation and resubmit the request for payment to the Agency within ten (10) calendar days from the date the statement is received by the Corporation.

(e) The amount paid to the Lender pursuant to a Demand Letter shall be less than the amount contained in the Demand Letter only under the following circumstances:

(1) The Demand contains an incorrect calculation of amount owing;

(2) Lender failed to comply with the collateral requirements contained in the Guarantee. The Agency or Corporation shall calculate the estimated value of the missing Security based upon immediate sale value and subtract the amount from any principal and/or interest then due and owing on the Loan; or

(3) The amount owing on the Loan has been reduced by subsequent payments from the Borrower to the Lender.

(f) Within one working day of receiving the check pursuant to subsection (d)(1) above, the Corporation shall contact the Lender and arrange to deliver the check to the Lender. The Corporation shall deliver the check simultaneously with receipt of an assignment of the Lender's interest in the Loan. The Loan shall be assigned to the Corporation, and shall include all Security and the Loan note.

(g) The Guarantee document shall include a provision for binding arbitration in the event that either the Corporation or Agency denies the requested Demand pursuant to subsections (c)(2) or (d)(2), or the amount paid to the Lender is less than the amount contained in the Demand Letter.

(h) Demand must be made upon the Corporation no later than noon on the thirty–first day following the date on which the Guarantee terminates; provided, however, that if the thirty–first is not a day upon which the Corporation is open for business, the last day for making a Demand shall occur on the next succeeding day upon which the Corporation is open for business.

NOTE: Authority cited: Section 14075 (b), Corporations Code. Reference: Section 14075 (a), Corporations Code; and Section 8684.2, Government Code.

HISTORY

1. New section filed 12–8–89 as an emergency; operative 12–8–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4–9–90.
2. Amendment of subsection (d)(2) and new subsection (d)(3) filed 12–22–89 as an emergency; operative 12–22–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed by operation of law on 4–23–90.
3. Certificate of Compliance as to 12–8–89 and 12–22–89 orders including nonsubstantive amendments transmitted to OAL 4–6–90 and filed 5–7–90 (Register 90, No. 25).
4. Amendment of subsection (f) filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of printing error in subsection (d)(3) (Register 91, No. 32).
6. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
7. Renumbering of former section 4013 to section 4613 and new section 4013 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
8. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
9. Editorial correction of HISTORY 8 (Register 2005, No. 27).
10. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 4014. Application Content.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; Section 15335, Government Code.

HISTORY

1. New section filed 12–8–89 as an emergency; operative 12–8–89 (Register 89, No. 52). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 4–9–90.
2. Certificate of Compliance as to 12–8–89 order including nonsubstantive amendments transmitted to OAL 4–6–90 and filed 5–7–90 (Register 90, No. 25).
3. Renumbering and amendment of former section 4014 to section 4016 filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
4. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
5. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of History 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

Article 2. Small Business Loans

§ 4015. Small Business Loan Agreement and Guarantee Terms.

(a) The terms and conditions of a Loan Agreement to a Small Business shall include all of the following:

(1) Except for an Extended Guarantee, as defined in subsection (b)(6), the maximum interest rate shall be determined based upon the percentage of the Loan which is guaranteed by a Corporation, as set forth below in subsections (A) through (D). The interest rate for an Extended Guarantee shall not exceed Prime plus two percent.

(A) If the percentage guaranteed is 95 percent, the maximum Loan interest rate shall be Prime;

(B) If the percentage guaranteed is 90 percent, the maximum Loan interest rate shall be Prime plus one percent;

(C) If the percentage guaranteed is 85 percent, the maximum Loan interest rate shall be Prime plus two percent;

(D) If the percentage guaranteed is 80 percent, the maximum Loan interest rate shall be Prime plus three percent;

(2) If the Borrower receives a Federal Disaster Loan, all proceeds from the Federal Disaster Loan shall be used to reduce the Loan, to the extent allowed by law.

(3) The Lender shall be authorized to charge reasonable administrative loan fees.

(4) In the case of a Loan with an Extended Guarantee, as defined in subsection (b)(6), the Loan shall be fully amortized. As used in this subsection, "fully amortized" means that periodic and equal interest and principal payments are due throughout the term of the Loan.

(b) The terms and conditions of a Guarantee shall be consistent with the resolution of the Corporation approving the Guarantee and shall include all of the following:

(1) The Corporation promises to pay up to 95 percent of the Loan principal and interest (100 percent if the conditions of subclause (2) below are met) in the event of a Default, subject only to the following restrictions:

(A) Such amount does not exceed a total of $150,000 principal, plus the interest on the guaranteed portion of the Loan.

(B) The Lender has complied with any conditions contained in the resolution adopted by a Corporation's board of directors authorizing the Guarantee; provided, however, that this restriction only shall apply to the extent that the conditions in such resolution are expressly set forth in the Guarantee; and

(C) The Lender has not engaged, and will not engage, in fraudulent or grossly negligent practices in connection with the Borrower, Guarantee, the Loan or the Loan Agreement.

(2) In the case of a Loan to a Small Business, the Guarantee shall include a promise to repay up to 100 percent of the Loan interest and principal if access to business records pertinent to the Application for a Loan has been precluded by official action prohibiting necessary reentry into the affected business premises. Evidence of the above shall consist of a written statement of the Lender, Corporation, or public official confirming the denial of access. In addition, the Borrower shall also specify in writing the relevant records within the business premises, and certify that no other copies of such records exist.

(3) Neither the terms of the Guarantee nor the Loan shall be amended without the prior written approval of the Borrower, Lender and the Corporation executing the Guarantee.

(4) The Lender shall make a good faith effort to send to the Corporation executing the Guarantee, a copy of all correspondence mailed to the Borrower.

(5) Section 4013 Demand Procedures.

(6) The original term of a Guarantee shall not exceed twelve (12) months. A Corporation is authorized to extend the term of a Guarantee upon expiration of the initial twelve (12) month term so long as a Federal Disaster Loan Application is still pending. The extension shall continue only so long as the Application remains pending. If a Federal Disaster Loan Application is denied, a Corporation is authorized to issue a Guarantee for a new Loan for a term not to exceed seven years. The amount of the new Loan shall not exceed the total owing on the previous Loan as of the date the Application was denied. A Guarantee issued after an Application has been denied is defined as an "Extended Guarantee." No Extended Guarantee shall be issued unless the Corporation obtains and reviews updated financial and credit information concerning the Borrower. The Corporation is only required to review information which updates financial and credit information contained in the original Application.

(7) No Corporation shall be authorized to charge a Guarantee fee for issuing a Small Business Guarantee, except for the issuance of an Extended Guarantee, as defined in subsection (b)(6). A Corporation shall be authorized to charge a fee of up to one percent of the Guarantee amount in the case of an Extended Guarantee.

NOTE: Authority cited: Section 14075(b), Corporations Code. Reference: Section 14075(a), Corporations Code; and section 8684, Government Code.

HISTORY

1. Renumbering and amendment of section 4012 to section 4015 filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of printing error in subsection (a)(2) (Register 91, No. 32).
3. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
4. Renumbering of former section 4015 to section 4615 and new section 4015 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
5. Amendment of subsection (b)(1)(A) and NOTE filed 8–10–92 as an emergency; operative 8–10–92 (Register 92, No. 33). A Certificate of Compliance must be transmitted to OAL 12–8–92 or emergency language will be repealed by operation of law on the following day.
6. Order of 8–10–92 repealed by operation of Government Code section 11346.1 (Register 94, No. 17).
7. Editorial correction of subsections (a)(1)(D), (b)(1), and (b)(2) (Register 95, No. 13).

§ 4016. Eligibility for a Guarantee to a Small Business.

A Corporation shall only execute a Guarantee to a Small Business upon a finding of eligibility. A finding of eligibility shall include all of the following:

(a) The Borrower is the owner of a Small Business.

(b) At least 50 percent of the Borrower's revenue during the calendar year in which the Disaster occurred originated from locations in the Disaster Area.

(c) Loan proceeds will be used exclusively to fund Physical Damage and/or Economic Injury costs.

(d) Borrower is creditworthy.

(e) The Corporation determines that the Loan meets the requirements for available Small Business Administration Physical Disaster Loan or Economic Disaster Loan pursuant to 13 C.F.R. section 123, subparts C and D, and that the Borrower has submitted an Application to the Small Business Administration pursuant to these subparts.

NOTE: Authority cited: Section 14075(b), Corporations Code. Reference: Section 14075(a), Corporations Code; and Section 8684.2, Government Code.

HISTORY

1. Renumbering and amendment of former section 4014 to section 4016 filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
3. Renumbering of former section 4016 to section 4616 and new section 4016 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
4. Amendment of subsections (b) and (e) and amendment of NOTE filed 7–7–2005; operative 7–7–2005 (Register 2005, No. 27).

§ 4017. Authority Approval.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. New section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
2. Change without regulatory effect amending subsection (e)(6) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2005, No. 27).
5. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

Article 3. Farm Enterprise Loans

§ 4018. Farm Enterprise Loan Agreement and Guarantee Terms.

(a) The terms and conditions of a Loan Agreement to a Farm Enterprise shall include all of the following:

(1) The maximum interest rate shall be determined based upon the percentage of the Loan which is guaranteed by a Corporation, as follows:

(A) If the percentage guaranteed is 95 percent, the maximum Loan interest rate shall be Prime.

(B) If the percentage guaranteed is 90 percent , the maximum Loan interest rate shall be Prime plus one percent.

(C) If the percentage guaranteed is 85 percent, the maximum Loan interest rate shall be Prime plus two percent.

(D) If the percentage guaranteed is 80 percent, the maximum Loan interest rate shall be Prime plus three percent.

(2) The Lender shall be authorized to assess reasonable charges upon the Borrower based upon Lender's out of pocket expenses in connection

with the Loan. An example would be the cost of a title report for a loan secured by real property. Lender is also authorized to charge a Loan fee of up to one and one–half percent (1.5%) of the Loan amount.

(b) The terms and conditions of a guarantee shall include:

(1) The maximum Guarantee amount per borrower per disaster shall be five hundred thousand dollars ($500,000) plus the interest owed on that amount.

(2) A requirement that the Lender has complied with any conditions contained in the resolution adopted by a Corporation's board of directors authorizing the Guarantee; provided, however, that this restriction only shall apply to the extent that the conditions in such resolution are expressly set forth in the Guarantee.

(3) A requirement that the Lender has not engaged, and will not engage, in fraudulent or grossly negligent practices in connection with the Borrower, Guarantee, the Loan or the Loan Agreement.

(4) A statement that neither the terms of the Guarantee nor the Loan shall be amended without the prior written approval of the Borrower, Lender and the Corporation executing the Guarantee.

(5) A requirement that the Lender make a good faith effort to send to the Corporation executing the Guarantee, a copy of all correspondence mailed to the Borrower.

(6) Inclusion of the section 4013 Demand Procedures.

(7) The term of the Guarantee shall not exceed seven years.

(8) Corporations shall be authorized to charge a Guarantee fee not to exceed one percent of the Guarantee amount for issuing a Farm Enterprise Guarantee.

NOTE: Authority cited: Section 14075(b), Corporations Code. Reference: Section 14075(a), Corporations Code.

HISTORY

1. New section filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–9–91 including amendment of subsection (b)(7) as an emergency; operative 4–9–91 (Register 91, No. 25). A Certificate of Compliance must be transmitted to OAL by 8–7–91 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of printing error removing erroneous former HISTORY 2. (Register 91, No. 25).
4. Repealer and new section filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
5. Renumbering of former section 4018 to section 4618 and new section 4018 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
6. Editorial correction of printing error in HISTORY 4. (Register 92, No. 37).
7. Amendment of subsections (a)(2) and (b)(1) filed 6–15–95 as an emergency; operative 6–15–95 (Register 95, No. 24). A Certificate of Compliance must be transmitted to OAL by 12–12–95 or emergency language will be repealed by operation of law on the following day.
8. Amendment of subsection (b)(1) filed 6–24–96; operative 6–24–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 26).
9. Amendment of subsections (a)(1)(A)–(C) and (b)(1)–(2) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
10. Editorial correction of HISTORY 9 (Register 2005, No. 27).
11. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 4019. Eligibility for a Guarantee to a Farm Enterprise.

(a) A Corporation shall only execute a Guarantee to a Farm Enterprise upon a finding of eligibility. The Corporation's board of directors shall adopt a resolution that the Borrower and the Loan meet each of the eligibility findings. The eligibility resolution will be part of the board of directors' minutes of the meetings in which the Guarantee was approved. A finding of eligibility shall include all of the following:

(1) The Borrower is the owner of a Farm Enterprise.

(2) The Guarantee is necessary because the Farm Enterprise suffered a significant economic injury related to the disaster.

(3) At least 50 percent of the Borrower's revenue during the calendar year in which the disaster occurred originated from locations in the Disaster Area.

(4) Loan proceeds will be used to fund Physical Damage and/or Economic Injury costs.

(A) One year of operating expenses shall be included as part of the Economic Injury costs, if necessary to sustain the farm production.

(5) Borrower is creditworthy.

(6) Loan proceeds will not be used to bring the Borrower's economic circumstances to a condition better than before the disaster occurred.

(7) The total approved Guarantees will not exceed the total authorized by the Agency.

(8) Loans approved are in accordance with Section 14071 of the California Corporations Code.

(b) Loan Guarantees as provided in subsection (a)(4)(A) shall be eligible for renewal on a yearly basis.

(c) An eligible Borrower is eligible for the following Guarantees:

(1) One Line of Credit Guarantee. The term of the Line of Credit Guarantee cannot exceed twenty–four (24) months. The Guarantee must be issued within six–months of receipt of the Borrower's original Application. Upon the maturity of the Line of Credit, the Line of Credit Guarantee can be renewed or converted into a term loan in amounts less than or equal to the original Line of Credit Guarantee. A renewed Line of Credit Guarantee would be issued for an additional period that cannot exceed twenty–four (24) months. A Line of Credit Guarantee converted into a term loan would be fully amortizing over a seven–year period.

(2) One Term Loan Guarantee. The term loan can have up to a 12–month interest–only period; however, the Term Loan must be fully amortized on the seven–year maturity date. The Guarantee must be issued within six–months of receipt of the Borrower's original Application.

(d) A Borrower may receive one or more additional Guarantees, which can be either Term Loans or Line of Credit Guarantees, provided the purpose of the additional Guarantee(s) is to preserve collateral and/or prevent the State from paying a loss claim on a Guarantee made to a Borrower under subsection (c) of this section. The Corporation must obtain permission from the Director in writing before issuing an additional Guarantee.

NOTE: Authority cited: Section 14075(b), Corporations Code. Reference: Sections 14060, 14067, 14068, 14071 and 14075(a), Corporations Code.

HISTORY

1. New section filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
3. Renumbering of former section 4019 to section 4619 and new section 4019 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
4. Amendment of subsection (c), new subsections (c)(1)–(3) and amendment of NOTE filed 2–11–2002; operative 3–13–2002 (Register 2002, No. 7).
5. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

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Title 10. Investment

Chapter 6.52. Defense Adjustment Matching Grant Program

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Chapter 6.52. Defense Adjustment Matching Grant Program

§ 4020.1. Definitions.

(a) "Agency" means the California Trade and Commerce Agency.

(b) "Applicant" means an Eligible Community which has applied to the Agency for a Grant.

(c) "Application" means the information and attachments, described in sections 4020.4, 4020.5, and 4020.6.

(d) "Base Closure" means the closure of a military base, or relocation of some of the base's activities to another site, which results in job loss within the Applicant's jurisdiction.

(e) "Defense Conversion" means the transition of defense industries, and suppliers to those industries, from defense–related production to production for civilian markets.

(f) "Defense Adjustment" means the effects of Base Closure and/or Defense Conversion, including the transition–related impacts on communities and workers supporting those industries (e.g. layoffs, erosion of tax base, retraining needs), within an Applicant's jurisdiction.

(g) "Eligible Community" means a California city, county, city and county, a joint powers authority between one or more cities and/or counties impacted by Defense Adjustment, a Special District of city or county, or a Non–profit Corporation that has been invited to apply for, or has received a commitment of Federal Assistance.

(h) "Federal Assistance" means a Defense Adjustment grant provided by an agency of the federal government requiring a non–federal match for which the Applicant is requesting a Grant.

(i) "Full Time Employee" means one or more persons working one thousand, seven hundred fifty (1750) hours (or more) in a twelve (12) month period.

(j) "Grant" means an award of California Defense Adjustment Matching Grant funding pursuant to this chapter which need not be repaid.

(k) "Implementation Grant" means a Grant to implement one or more elements contained in either a previously developed plan or the Application, and which addresses Defense Adjustment within the Applicant's jurisdiction. Eligible Communities may use Implementation Grants to fund detailed, specific plans addressing the provisions of utilities or traffic circulation.

(*l*) "Planning Grant" means a Grant to develop a plan for addressing Defense Adjustment within the Applicant's jurisdiction. Planning Grants shall not be used to fund detailed, specific plans addressing the provision of utilities or traffic circulation.

(m) "Special District" means a unit of local government.

(n) "Non–profit Corporation" means an organization which has received a determination letter to that effect from the Internal Revenue Service pursuant to Section 501(c) of the Internal Revenue Code of 1986.

(o) "Federal Funding Agency" means any agency or department of the federal government providing funds for Defense Adjustment activities.

(p) "Federal Assistance Contract" means the executed agreement between the Applicant and a Federal Agency funding planning or implementation initiatives to be undertaken to remediate the negative affects of Defense Adjustment.

NOTE: Authority cited: Section 15330, Government Code. Reference: Section 15332, Government Code.

HISTORY

1. Repealer of former chapter 6.52 (sections 4020–4023) and new chapter 6.52 (sections 4020.1–4020.5) filed 7–13–93 as an emergency; operative 7–13–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–10–93 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 92, No. 39.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Repealed by operation of Government Code section 11346.1(g) (Register 94, No. 7).
4. New section filed 2–16–94; operative 2–16–94 pursuant to Government Code section 11343.4(d) (Register 94, No. 7).
5. Editorial correction of HISTORY 1 (Register 94, No. 7).
6. Editorial correction of HISTORY 1 and 3, adding new HISTORY 4, and HISTORY note renumbering (Register 95, No. 22).
7. Amendment of subsections (e)–(g), new subsections (m)–(n) and amendment of NOTE filed 10–13–95 as an emergency; operative 10–13–95 (Register 95, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–10–96 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 10–13–95 order transmitted to OAL 1–30–96 and filed 3–13–96 (Register 96, No. 11).
9. Amendment of subsections (g) and (i) and new subsections (o) and (p) filed 12–4–96; operative 12–4–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 49).
10. Amendment of subsections (c), (f), (g) and (j)–(*l*) filed 6–18–99; operative 7–18–99 (Register 99, No. 25).

§ 4020.2. Application Process.

(a) The Agency shall be authorized to establish funding cycles on a periodic basis throughout the fiscal year. At the beginning of each fiscal year the Agency shall send a letter announcing the availability of Grants, "Solicitation" to all California cities, counties, cities and counties, and to any person requesting information about Grants. The Solicitation shall include a description of the Application process and the Application deadline. The first Application deadline shall be no later than thirty (30) calendar days following the mailing of the Solicitation. Potential Applicants may request copies of the Solicitation in writing, via facsimile, or by electronic mail. For the purposes of this section, fiscal year means the period commencing July 1 and ending June 30th of the following year.

(b) Not later than the deadline described in the subsection (a) Solicitation, each Applicant shall submit an original and four (4) copies of a completed Application to the Agency.

(c) Not later than fifteen (15) business days following the deadline described in the subsection (a) Solicitation, the Agency shall mail a letter to each Applicant which submitted an incomplete or ineligible Application, "Notice of Completion and Eligibility". If the Application is incomplete, the Notice of Completion and Eligibility shall describe the missing or incomplete information. The Applicant shall provide the missing or incomplete information to the Agency not later than 5 p.m., ten (10) business days following the mailing of the Notice of Completion and Eligibility. The Agency shall only accept materials directly related to the issue(s) described in the Notice of Completion and Eligibility. If the Application is ineligible, the Notice of Completion and Eligibility shall explain why the Application does not meet the requirements described in section 4020.3. Applicants which submit Applications that do not meet the requirements described in section 4020.3 shall not have an opportunity to submit additional information and shall be disqualified from further review by the Agency.

(d) Not later than sixty (60) calendar days following the deadline described in subsection (a) Solicitation, the Agency shall mail to each Applicant which submitted an eligible Application either a notice disapproving the funding request or a letter of conditional grant award based upon the Section 4020.5(h) funding determination. The notice disapproving the funding request shall explain why the Application will not be funded. The letter of conditional grant award shall describe the amount of the Applicant's Grant and include a statement indicating disbursement of the Grant is conditioned upon the Applicant receiving Federal Assistance consistent with the Application.

(e) A Grant agreement shall not be prepared until the Applicant delivers to the Agency an executed copy of the Federal Assistance Contract. Upon receipt of the executed Federal Assistance Contract, the Agency and Applicant shall mutually agree upon and execute a Grant agreement.

(f) The Agency shall be authorized to award an Applicant less than the amount described in the subsection (d) letter of conditional grant award if such a reduction is necessary to remain within the federal match requirements described in subsections 4020.3(d) and (f).

NOTE: Authority cited: Section 15330, Government Code. Reference: Section 15332, Government Code.

HISTORY

1. New section filed 7–13–93 as an emergency; operative 7–13–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–10–93

or emergency language will be repealed by operation of law on the following day.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Repealed by operation of Government Code section 11346.1(g) (Register 94, No. 7).
4. New section filed 2–16–94; operative 2–16–94 pursuant to Government Code section 11343.4(d) (Register 94, No. 7).
5. Editorial correction of HISTORY 1 (Register 94, No. 7).
6. Editorial correction of HISTORY 1 and 3, adding new HISTORY 4, and HISTORY note renumbering (Register 95, No. 22).
7. Amendment of section and NOTE filed 10–13–95 as an emergency; operative 10–13–95 (Register 95, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–10–96 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 10–13–95 order including editorial correction of subsections (c) and (d) transmitted to OAL 1–30–96 and filed 3–13–96 (Register 96, No. 11).
9. Amendment filed 12–4–96; operative 12–4–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 49).
10. Amendment filed 6–18–99; operative 7–18–99 (Register 99, No. 25).

§ 4020.3. Eligible Application.

An eligible Application is one which meets all of the following requirements:

(a) It is submitted by an Applicant.

(b) The Applicant is the same Applicant identified in the Federal Assistance award.

(c) The Application is for either a Planning Grant or an Implementation Grant addressing Defense Adjustment within the Applicant's jurisdiction. The Agency shall award no more than two (2) Planning Grants to each of the jurisdictions constituting the Applicant.

(d) The amount of funds applied for is at least ten thousand dollars ($10,000) but not more than one hundred, fifty thousand dollars ($150,000), except as provided for in subsection 4020.5(i).

(e) Grant funds shall be used to reimburse costs associated with activities outlined in new Federal Assistance contracts or for elements of existing Federal Assistance contracts for which no work has yet been undertaken.

(f) The Grant shall not exceed fifty percent (50%) of the non–federal match requirement for Federal Assistance.

(g) Grants funds shall only be used to fund the non–federal match requirements for Federal Assistance.

NOTE: Authority cited: Section 15330, Government Code. Reference: Section 15332, Government Code.

HISTORY

1. New section filed 7–13–93 as an emergency; operative 7–13–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–10–93 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 94, No. 7).
3. New section filed 2–16–94; operative 2–16–94 pursuant to Government Code section 11343.4(d) (Register 94, No. 7).
4. Editorial correction of HISTORY 1 (Register 94, No. 7).
5. Editorial correction of HISTORY 1 and 2, adding new HISTORY 3, and HISTORY note renumbering (Register 95, No. 22).
6. Amendment of section and NOTE filed 10–13–95 as an emergency; operative 10–13–95 (Register 95, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–10–96 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 10–13–95 order transmitted to OAL 1–30–96 and filed 3–13–96 (Register 96, No. 11).
8. Amendment filed 12–4–96; operative 12–4–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 49).
9. Repealer and new section filed 6–18–99; operative 7–18–99 (Register 99, No. 25).

§ 4020.4. Application. General Information.

The Application shall contain the items described below and the items described in sections 4020.5 and 4020.6. The items listed in subsections (a) through (h) shall be on the first page of the Application.

(a) The Applicant's name, address, county, telephone and facsimile numbers, e–mail address (if applicable), and federal tax identification number.

(b) The name and title of the Applicant's Authorized Representative and the Authorized Representative's address and telephone and facsimile number, if different than subsection (a). As used in this section, "Authorized Representative" means the person authorized by the governing body of the Applicant to execute the subsection 4020.2(e) Grant agreement and any and all amendments or revisions thereto.

(c) The name and title of the Applicant's contact person and the contact person's address, and telephone and facsimile number, if different than subsection (a).

(d) The amount of the Grant request and a statement indicating whether the Applicant is applying for a Planning Grant or an Implementation Grant.

(e) If appropriate, other state funds available for the implementation of the Defense Adjustment project or the development of the Defense Adjustment plan described in the Application.

(f) The amount of in–kind and cash contributions to be provided by the Applicant.

(g) A description of the Applicant's Federal Assistance award including following information:

(1) The name of the Federal Funding Agency and the name of the program to which the Applicant has applied to for funding Federal Assistance.

(2) The amount of Federal Assistance required by the Applicant.

(3) The Applicant's Federal Assistance award number, if available.

NOTE: Authority cited: Section 15330, Government Code. Reference: Section 15332, Government Code.

HISTORY

1. New section filed 7–13–93 as an emergency; operative 7–13–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–10–93 or emergency language will be repealed by operation of law on the following day.
2. Change without regulatory effect amending subsection (f) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Repealed by operation of Government Code section 11346.1(g) (Register 94, No. 7).
4. New section filed 2–16–94; operative 2–16–94 pursuant to Government Code section 11343.4(d) (Register 94, No. 7).
5. Editorial correction of HISTORY 1 (Register 94, No. 7).
6. Editorial correction of HISTORY 1 and 3, adding new HISTORY 4, and HISTORY note renumbering (Register 95, No. 22).
7. Amendment of section and NOTE filed 10–13–95 as an emergency; operative 10–13–95 (Register 95, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–10–96 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 10–13–95 order including repealer of subsection (h) transmitted to OAL 1–30–96 and filed 3–13–96 (Register 96, No. 11).
9. Amendment filed 12–4–96; operative 12–4–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 49).
10. Repealer and new section filed 6–18–99; operative 7–18–99 (Register 99, No. 25).

§ 4020.5. Application. Scored Sections.

(a) In addition to the items described in section 4020.4 and 4020.6, each Application shall contain the information listed in subsections (b) through (g). A panel consisting of not fewer than three (3) nor more than six (6) professional, full–time employees of the Agency shall evaluate all eligible Applications based upon the categories and point values described in subsections (b) through (g) and the scoring methods described in subsection (h).

(b) Lead Agency: The local agency responsible for administering the Grant. If the Lead Agency is a local reuse authority five (5) points will be awarded. If the lead agency is not a local reuse authority zero (0) points will be awarded. As used in this section "local reuse authority" means a city, county, joint powers authority, or non–profit corporation which has been designated by a jurisdiction to oversee it base reuse activities.

[The next page is 829.]

(c) Award Frequency (0 to 5 points): The number of Grants awarded to the Applicant by the Agency.

(1) Five (5) points will be awarded to Applicants which have never received a Grant; three (3) points to Applicants which have received one (1) prior Grant; and zero (0) points to Applicants which have received two (2) or more prior Grants.

(2) Applicants which submit more than one (1) funding request in a Grant cycle shall prioritize each Application submitted based upon the needs which exist in the Applicant's jurisdiction. If the Application with highest priority is selected for funding, the Agency shall lower the scores of the other Applications submitted by the Applicant pursuant to the procedures described in subsection (c)(1).

(d) Grant Type: (0 to 10 points): Applications for Planning Grants shall be awarded up to ten (10) points. Applications for Implementation Grants shall be awarded up to 5 points if the proposed project contained in the Application includes infrastructure projects or job–creation projects located on a military base in the Applicant's jurisdiction. Applications for Implementation Grants which do not include infrastructure projects or job–creation projects located on a military base in the Applicant's jurisdiction shall be awarded up to two (2) points. As used in this section "infrastructure projects" means programs and initiatives the Applicant will implement in its jurisdiction to improve or build physical systems and services which support development and people. Examples of infrastructure projects include, but are not limited to, utilities and service systems including: power or natural gas, communications systems, local or regional water treatment or distribution facilities, sewer or septic tanks, storm water drainage, solid waste disposal, and circulation. As used in this section "Job creation projects" means programs and initiatives the Applicant will implement in its jurisdiction to develop full–time jobs.

(1) Applications for Planning Grants shall include the following:

(A) A description of how the proposed plan relates to and is different from previously prepared plans or previously implemented projects which address Defense Adjustment in the Applicant's jurisdiction. All previously prepared plans addressing Defense Adjustment in the Applicant's jurisdiction shall be attached to the Application as Exhibit A.

(B) A list of the organizations that will be involved in implementing the proposed plan.

(C) A description of the short– and long–term goals of the proposed plan.

(D) A description of previous and current outreach efforts directed toward businesses and organizations in the Applicant's jurisdiction which have been adversely affected by Defense Conversion.

(E) Other proposals for Defense Adjustment in the Applicant's jurisdiction.

(2) Applications for Implementation Grants shall include the following:

(A) The number and type of full–time jobs the proposed implementation project is expected to directly create or retain during the three (3) year period following the award of the Grant. This description shall include an explanation of how this estimate was derived, identify the amount of Grant funding necessary to create or retain each position, and list the dollar amount and source of any other funding the Applicant will use for job creation or retention.

(B) A description of the Applicant's Defense Adjustment strategy and how the proposed implementation project supports this strategy. If the Applicant's Defense Adjustment strategy is contained in an existing plan, attach this plan as Exhibit A.

(C) A description of the short– and long–term goals of the proposed implementation project.

(D) A description of previous and current outreach efforts directed toward businesses and organizations in the Applicant's jurisdiction which have been adversely affected by Defense Conversion.

(E) Other proposals for Defense Adjustment within the Applicant's jurisdiction.

(e) Need: 0 to 10 points.

(1) The Applicant's reasons for not providing the entire non–federal match required to receive Federal Assistance.

(2) The Applicant's efforts to obtain non–federal funding for the Federal Assistance project from sources other than the Agency. Include as Exhibit J a declaration from the Applicant's budget officer or chief administrative officer certifying that other sources of funds are not available.

(3) The adverse impacts experienced by the Applicant's jurisdiction or adjacent jurisdictions as a result of Defense Adjustment including: the percentage of job loss and indirect job loss using the categories contained in the current version of the North American Industry Classification System (NAICS), and reductions in community services and revenues. This description shall also include the potential impact to the Applicant's jurisdiction if the Grant request is denied.

(f) Regional Impact: 0 to 10 points. How the proposed project will directly assist the Applicant in addressing local and regional economic needs. Indicate how the proposed project will be linked, through shared initiatives or collaborative activities, to regional business and community development resources for the purpose of addressing regional and local aspects of base reuse and to complete the scope–of–work outlined in the Federal Assistance grant. Examples of community development resources include: community colleges, economic development groups, chambers of commerce, professional or industrial associations, regional marketing associations, Team California (a cooperative network of public and private economic development leaders that bring together resources and expertise from organizations throughout the state to promote business investment and job creation), or the Defense Marketing Association (a statewide advertising collaborative initiated by the Agency to combat the devastating loss of jobs caused by the closure and downsizing of major military bases and numerous defense facilities in California).

(g) Achievements: 0 to 10 points. Indicate what has been accomplished to date to advance the conversion and reuse of military bases in the Applicant's jurisdiction including a description of how local, federal, and state grants previously awarded to the Applicant for Defense Adjustment were used and the efficiency and effectiveness of the projects funded with those grants.

(h) Applications receiving a total score of twenty–five (25) or more points shall be ranked and funded in descending order by number of points scored until all available funds have been committed except as provided for in subsection (i). Applications scoring below twenty–five (25) points shall be disqualified from current consideration but may reapply during a subsequent funding cycle. In the event of a tie score between two or more Applicants whose total request for matching funds exceeds the remaining Grant funds available, the Agency shall apply the following "tie–breaker" protocol: the Applicant awarded the most points pursuant to the subsection 4020.5(e) criterion shall win the tie–breaker. If both Applicants received the same number of points on the subsection 4020.5(e) criterion, the Applicant awarded the most points pursuant to subsection 4020.5(f) criterion shall win the tie–breaker.

(i) The Agency shall be authorized to set–aside up to ten percent (10%) of the Grant money allocated by the Legislature for award to Applicants which did not qualify for funding pursuant to subsection (h). The Agency shall award the ten percent (10%) set–aside to Applicants which requested Grants of $50,000 or less and received a total score of twenty–five or more points. The Applicants shall be ranked and funded in descending order by number of points scored until all of the available set–aside funds have been committed.

NOTE: Authority cited: Section 15330, Government Code. Reference: Section 15332, Government Code.

HISTORY

1. New section filed 7–13–93 as an emergency; operative 7–13–93 (Register 93, No. 29). A Certificate of Compliance must be transmitted to OAL by 11–10–93 or emergency language will be repealed by operation of law on the following day.

2. Change without regulatory effect amending subsections (a) and (b)–(d) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Repealed by operation of Government Code section 11346.1(g) (Register 94, No. 7).
4. New section filed 2–16–94; operative 2–16–94 pursuant to Government Code section 11343.4(d) (Register 94, No. 7).
5. Editorial correction of HISTORY 1 (Register 94, No. 7).
6. Editorial correction of HISTORY 1 and 3, adding new HISTORY 4, and HISTORY note renumbering (Register 95, No. 22).
7. Amendment of section and NOTE filed 10–13–95 as an emergency; operative 10–13–95 (Register 95, No. 41). A Certificate of Compliance must be transmitted to OAL by 2–10–96 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 10–13–95 order transmitted to OAL 1–30–96 and filed 3–13–96 (Register 96, No. 11).
9. Amendment filed 12–4–96; operative 12–4–96 pursuant to Government Code section 11343.4(d) (Register 96, No. 49).
10. Repealer and new section filed 6–18–99; operative 7–18–99 (Register 99, No. 25).

§ 4020.6. Application. Exhibits.

The Application shall contain the following exhibits, as needed:

(a) Attach as Exhibit A for a Planning Grant or an Implementation Grant request, the relevant planning document.) Attach as Exhibit B either:

(1) A copy of the executed Federal Assistance contract between the Applicant and the Federal Funding agency, or

(2) A copy of the Federal Assistance application, or

(3) A copy of the previously submitted preliminary Federal Assistance application along with a letter from the Federal Funding agency indicating support of the preliminary application and requesting the Applicant to submit a complete application.

(c) Attach as Exhibit C a resolution adopted by the governing body of the Applicant authorizing the Applicant to submit the Application to the Agency and specifying a person authorized to execute the Grant contract and any and all amendments or revisions thereto, "Authorized Representative".

(d) Attach as Exhibit D both a description of the organizational structure for administering the Grant and managing the proposed project, and the resume and/or job description of the person who will administer the project.

(e) Attach as Exhibit E a detailed scope–of work for the activities to be funded by the Grant.

(f) Attach as Exhibit F a budget describing the Applicant's cash, in–kind and total sources of funds for the proposed project, and the uses of funds divided into federal, other state, and other funding sources. Include the following line items: personnel (salary and fringe), travel, supplies, postage, printing, contractual, other (specify), total direct charges, total indirect charges and total authorized budget.

(g) Attach as Exhibit G duty statements and position descriptions for any positions to be paid for by the Grant.

(h) Attach as Exhibit H copies of any and all consultant contracts or personal service agreements negotiated or under negotiation as part of the proposed project.

(i) Attach as Exhibit I a timeline identifying the tasks to be undertaken as part of the scope–of–work and their anticipated completion dates in relation to the initiation of the proposed project.

(j) Attach as Exhibit J as declaration from Applicant's budget or chief administrative officer certifying that other sources of funds are not available.

(k) Attach as Exhibit K a certificate signed and dated by the Authorized Representative described above in subsection (c) stating the following: "I hereby certify that the information provided in this Application is correct and represents the intended use of all sources of funds identified in the Application, and that I will inform the California Trade and Commerce Agency within ten (10) days of any changes in the funding proposal."

NOTE: Authority cited: Section 15330, Government Code. Reference: Section 15332, Government Code.

HISTORY

1. New section filed 6–18–99; operative 7–18–99 (Register 99, No. 25).

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Article 1. Definitions

§ 4025. Definitions.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Sections 15373, 15373.1, 15373.51, 15373.52, 15373.53 and 15373.54, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Reinsert chapter 6.53 and article 1 headings omitted in original printing and editorial correction of subsections (d) and (r)(4) (Register 90, No. 49).
3. Certificate of Compliance as to 4–23–90 order including amendment of subsections (h) and (r) transmitted to OAL 10–12–90 and filed 11–13–90 (Register 90, No. 51).
4. Change without regulatory effect amending subsections (e), (f) and (k) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Editorial correction of subsection (c) (Register 95, No. 13).
6. Change without regulatory effect repealing chapter (articles 1–3, sections 4025–4032), article 1 (section 4025) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

Article 2. Application Process

§ 4026. Applicant Eligibility.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Sections 15373.05, 15373.5, 15373.51, 15373.52 and 15373.54, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Reinsert Article 2 heading omitted in original printing. (Register 90, No. 49).
3. Certificate of Compliance as to 4–23–90 order including amendment of subsection (c) transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
4. Change without regulatory effect repealing article 2 (sections 4026–4030) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4027. Application.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Sections 15373.51, 15373.52, 15373.53 and 15373.54, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Certificate of Compliance as to 4–23–90 order including amendment of subsections (b) and (c) transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
3. Change without regulatory effect amending subsections (a) and (c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4028. Priority Factors.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Section 15373.53, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Certificate of Compliance as to 4–23–90 order including amendment transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
3. Change without regulatory effect amending subsection (a) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4029. Departmental Review of Applications.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Sections 15373.51, 15373.52, 15373.53 and 15373.54, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Editorial correction of subsections (d)(2) and (3) (Register 90, No. 49).
3. Certificate of Compliance as to 4–23–90 order including amendment of subsection (d) transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
4. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4030. Funding Periods.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Section 15373.53, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Certificate of Compliance as to 4–23–90 order including amendment transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

Article 3. Grants

§ 4031. Grant Agreement.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Sections 15373.51, 15373.53 and 15373.54, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Reinsert Article 3 heading omitted in original printing (Register 90, No. 49).
3. Certificate of Compliance as to 4–23–90 order including new subsection (f) transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
4. Change without regulatory effect amending opening paragraph and subsection (g) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing article 3 (sections 4031–4032) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4032. Grant Disbursements.

NOTE: Authority cited: Section 15373.07, Government Code. Reference: Sections 5373.51 and 15373.54, Government Code.

HISTORY

1. New section filed 4–23–90 as an emergency; operative 4–23–90 (Register 90, No. 20). A Certificate of Compliance must be transmitted to OAL within 180 days pursuant to Government Code section 15373.07 or emergency language will be repealed by operation of law on 10–20–90.
2. Certificate of Compliance as to 4–23–90 order transmitted to OAL 10–12–90 and filed 11–13–90. (Register 90, No. 51).
3. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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§ 4035. Definitions.

NOTE: Authority cited: Section 15328.5, Government Code. Reference: Section 15349, Government Code.

HISTORY

1. New chapter 6.54 (sections 4035–4038) filed 7–6–92; operative 8–5–92 (Register 92, No. 28).
2. Change without regulatory effect amending chapter heading, deleting article heading and amending subsection (c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing chapter (sections 4035–4038) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4036. Eligible Projects.

NOTE: Authority cited: Section 15328.5, Government Code. Reference: Section 15349, Government Code.

HISTORY

1. New section filed 7–6–92; operative 8–5–92 (Register 92, No. 28).
2. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4037. Applications.

NOTE: Authority cited: Section 15328.5, Government Code. Reference: Section 15349, Government Code.

HISTORY

1. New section filed 7–6–92; operative 8–5–92 (Register 92, No. 28).
2. Change without regulatory effect amending subsections (b), (c), (d), (e) and (g) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4038. Evaluation Criteria.

NOTE: Authority cited: Section 15328.5, Government Code. Reference: Section 15349, Government Code.

HISTORY

1. New section filed 7–6–92; operative 8–5–92 (Register 92, No. 28).
2. Change without regulatory effect amending opening paragraph filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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§ 4070. Definitions.

NOTE: Authority cited: Sections 11152 and 15330, Government Code. Reference: Sections 15330(c) and 15332(a), Government Code.

HISTORY

1. New chapter 6.55 (sections 4070–4074) filed 1–26–93; operative 2–25–93 (Register 93, No. 5).
2. Change without regulatory effect amending chapter heading, repealing article heading, and amending subsection (f) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing chapter (sections 4070–4074) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4071. Program Implementation.

NOTE: Authority cited: Sections 11152 and 15330, Government Code. Reference: Sections 15330(c) and 15332(a), Government Code.

HISTORY

1. New section filed 1–26–93; operative 2–25–93 (Register 93, No. 5).
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4072. Offset Credit Request Form.

NOTE: Authority cited: Sections 11152 and 15330, Government Code. Reference: Sections 15330(c) and 15332(a), Government Code.

HISTORY

1. New section filed 1–26–93; operative 2–25–93 (Register 93, No. 5).
2. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4073. Offset Credit Award Criteria.

NOTE: Authority cited: Sections 11152 and 15330, Government Code. Reference: Sections 15330(c) and 15332(a), Government Code.

HISTORY

1. New section filed 1–26–93; operative 2–25–93 (Register 93, No. 5).
2. Change without regulatory effect amending subsections (b)(4)–(5) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4074. Administrative Appeals.

NOTE: Authority cited: Sections 11152 and 15330, Government Code. Reference: Sections 15330(c) and 15332(a), Government Code.

HISTORY

1. New section filed 1–26–93; operative 2–25–93 (Register 93, No. 5).
2. Change without regulatory effect amending subsection (a) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 6.56. Manufacturing Technology Grant Program

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Chapter 6.56. Manufacturing Technology Grant Program

§ 4080.1. Definitions.

The following terms shall have the meanings set forth below:

(a) "Agency" means the California Trade and Commerce Agency.

(b) "Applicant" means a California nonprofit corporation or California public agency which has applied to the Agency for a Grant.

(c) "California nonprofit corporation" means a corporation organized and in good standing as a nonprofit corporation under Title I, Division 2 of the California Corporation Code.

(d) "California public agency" means any agency of the State of California, or any local California agency, including but not limited to a city, county, special district or joint powers agency consisting exclusively of state or local agencies.

(e) "Federal Award" means a Manufacturing Technology grant provided by an agency of the federal government requiring non–federal matching funds for which the Applicant is requesting a Grant.

(f) "Grant" means an award of funding pursuant to this chapter which need not be repaid.

(g) "In–kind Support" means resources other than money provided by the Applicant or private companies, nonprofit organizations, public agencies, and/or other entities involved in the implementation of the Proposal. Examples on In–kind Support include equipment; supplies; space and facilities; managerial, secretarial, financial, and other administrative services; and technical training.

(h) "Manufacturing Technology" refers to process of developing, disseminating, and/or implementing technical information used by manufacturers in the creation of goods and services.

(i) "Proposal" means the forms, program descriptions, and attachments described in section 4080.3.

(j) "Solicitation" means one or more pages explaining the Grant funding cycle which shall include, at a minimum, the following:

(1) Whether the funding cycle is tied to a specific federal program.

(2) Program deadlines.

(k) "Solicitation Deadlines" means the date and time specified in the Solicitation when all Proposals and attachments must be received by the Agency.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15379.15 and 15379.16, Government Code.

HISTORY

1. New chapter 6.56 (sections 4080.1–4080.5) and section filed 8–1–96 as an emergency pursuant to Government Code section 15378.99; operative 8–1–96 (Register 96, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–97 pursuant to Government Code section 15378.99 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 30).
3. New section filed 7–21–97 as an emergency; operative 7–21–97 (Register 97, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–18–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 10).
5. New chapter 6.56 (sections 4080.1–4080.5) and section filed 3–5–98 as an emergency; operative 3–5–98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–1–98 or emergency language will be repealed by operation of law on the following day.
6. Notice of erroneous filing filed 10–8–98; purported repeal and deletion of section filed in error on 9–2–98 is null and void and text as filed with Secretary of State on 3–5–98 remains in effect uninterrupted, HISTORY 5 has been amended to show correct Certificate of Compliance date, and former HISTORY 6 has been repealed (Register 98, No. 42).
7. Certificate of Compliance as to 9–1–98 order transmitted to OAL 8–28–98 and filed 10–13–98 (Register 98, No. 42).

§ 4080.2. Proposal Process.

(a) The Agency shall establish funding cycles on an annual and/or one–time basis.

(1) The Agency shall distribute Solicitations to all persons requesting information about annual funding cycles not less than sixty (60) calendar days prior to the Solicitation Deadline.

(2) The Agency shall distribute Solicitations to all persons requesting information about one–time funding cycles not less than thirty (30) calendar days prior to the Solicitation Deadline. However, the time period for distributing Solicitations for one–time funding cycles may be shortened from thirty (30) calendar days to ten (10) calendar days if a notice of a Federal Award is received by the Agency less than fifty (50) calendar days prior the federal deadline.

(b) Applicants shall mail one (1) original and four (4) copies of the Proposal to the address specified in the Solicitation. Proposals received after the Solicitation Deadline shall be ineligible for funding.

(c) No later than forty–five (45) calendar days following the Solicitation Deadline, the Agency shall mail a letter to all Applicants informing them if their funding request has been approved or disapproved.

(1) Letters disapproving a funding request shall state that a Grant was not awarded because:

(A) The Proposal was ineligible pursuant to section 4080.4, or;

(B) The Proposal scored insufficient points pursuant to Section 4080.5.

(d) When a funding cycle is tied to a specific Federal Award, Applicants selected for funding shall receive a letter which includes the amount of the Grant and a statement indicating the disbursement of the Grant is conditioned upon the Applicant receiving a Federal Award that is consistent with the Proposal submitted to the Agency, ("Letter of Conditional Grant Award") and the execution of a Grant agreement. Upon receipt of a copy of the notice announcing the Applicant's Federal Award, the Agency and the Applicant shall begin negotiating the terms of the Grant agreement. When terms mutually agreed upon by both parties have been reached, the Agency shall disperse the Grant to the Applicant.

(e) When a funding cycle is not tied to a specific Federal Award, Applicants selected for funding shall receive a letter which includes the amount of the Grant and a statement indicating that the disbursement of the Grant is conditioned upon the execution of a Grant agreement. When terms mutually agreed upon by both parties have been reached, the Agency shall disperse the Grant to the Applicant.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15379.15 and 15379.16, Government Code.

HISTORY

1. New section filed 8–1–96 as an emergency pursuant to Government Code section 15378.99; operative 8–1–96 (Register 96, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–97 pursuant to Government Code section 15378.99 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 30).
3. New section filed 7–21–97 as an emergency; operative 7–21–97 (Register 97, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–18–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 10).
5. New section filed 3–5–98 as an emergency; operative 3–5–98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–1–98 or emergency language will be repealed by operation of law on the following day.
6. Notice of erroneous filing filed 10–8–98; purported repeal and deletion of section filed in error on 9–2–98 is null and void and text as filed with Secretary of State on 3–5–98 remains in effect uninterrupted, HISTORY 5 has been amended to show correct Certificate of Compliance date, and former HISTORY 6 has been repealed (Register 98, No. 42).
7. Certificate of Compliance as to 9–1–98 order transmitted to OAL 8–28–98 and filed 10–13–98 (Register 98, No. 42).

§ 4080.3. Proposal Content.

(a) All Proposals shall include a completed Manufacturing Technology Program Proposal Form (6/97 revision date), a completed Manufacturing Technology Program Budget Form (6/97 Revision date), a Proposal body, a certification signed by the Applicant's authorized representative, and attachments as set forth in subsections (f) and (g). Each part of the Proposal shall begin on a separate sheet of paper and be

clearly labeled with a title at the top of the page. Copies of the Manufacturing Technology Program Proposal Form and the Manufacturing Technology Program Budget Form shall be provided in the Solicitation distributed to all interested persons pursuant to Sections 4080.2.

(b) The following information shall be included in the Manufacturing Technology Program Proposal Form:

(1) The Applicant's name, address, county, state legislative district, telephone number, and when available, e–mail address and facsimile number.

(2) The name and title of the Applicant's authorized representative.

(3) The project name.

(4) The amount of state Manufacturing Technology Program funds requested.

(5) When applicable, the following information regarding the federal program the Applicant has applied to for funding:

(A) The name of the federal agency and the name of the federal program the Applicant has applied to for funding.

(B) The amount of federal funds requested.

(C) The name of the entity applying for the Federal Award. If the entity applying for the Federal Award is different than the Applicant as designated in subsection (b)(1) above, the following information shall be provided:

(i) The entity's address, county, telephone number, and when available, e–mail address and facsimile number; and

(ii) The name and title of the entity's authorized representative.

(6) Whether or not confidential information is included in the Proposal. Applicants shall follow the procedure for designating confidential information set forth in Government Code section 6250 et seq.

(c) The following information shall be included in the Manufacturing Technology Program Budget Form:

(1) A description of all funding available to the Applicant for the implementation of the Proposal including:

(A) The amount of funding requested from the state Manufacturing Technology Program (shall not exceed thirty–three percent (33%) of the total funding for the Proposal);

(B) The amount of funding requested from other state agencies (Applicants shall include the name of the state agency and the state program applied to for funding);

(C) The amount of federal funding requested;

(D) The amount of funding provided by the Applicant (Applicants are required to provide a minimum of thirty–three percent (33%) of the total funding for the Proposal); and

(E) A description of the source and dollar value of In–kind support.

(2) A budget listing the proposed uses of the funding identified in subsection (c)(1), above including:

(A) The salary and benefits of the staff implementing the Proposal.

(B) Travel expenses.

(C) Operating expenses (Expenses related to the operation of the Proposal such as telephone, facsimile, office supplies, utilities, insurance, leases, and building operation and management. Operating expenses typically exclude expenses related to equipment and direct project materials.)

(D) Contractual Services (Services necessary for the implementation of the Proposal for which the Applicant will sub–contract. These are services undertaken by a service provider external to the Applicant's organization and include, but are not limited to: engineering, marketing, facilitation, and training. Required contractual services may vary from Applicant to Applicant and will be approved in the Grant agreement between the Applicant and the Agency or by the Manufacturing Technology Program manager prior to the execution of the Grant agreement.)

(E) Total direct charges (All costs directly identifiable to the Proposal including salaries, wages, benefits, contractual services, travel, operating expenses, and other expenses.)

(F) Total in–direct charges (The overhead rate, or costs shared among more than one program implemented by an Applicant, but by not readily attributed to a specific project. The amount of in–direct charges related to the Proposal is established by the Applicant, but it shall not exceed similar charges charged to the federal government under any Federal Award associated with the Proposal).

(G) Other expenses (shall be specified by the Applicant).

(d) The Proposal body shall include the following:

(1) A description of the manufacturing problem, service, process, or product addressed by the Proposal. This description shall include a discussion of any scientific and/or technological innovations included in the Proposal.

(2) A description of how the Proposal will directly respond to the needs of California manufacturers. This description shall include a discussion of how the Proposal will support the growth, improvement, and/or competitiveness of California manufacturers. Specific project objectives and activities shall also be described.

(3) A description of economic growth and/or job creation that is expected to result from the implementation of the Proposal. This description shall include a discussion of all manufacturing sectors impacted by the proposal and any work force training components.

(4) A description of the resources necessary to successfully develop the manufacturing process, service, or product described in the Proposal, including: capitalization, physical plant and equipment, engineering, and research and development.

(5) A description of how the Applicant intends to assemble the resources to develop the manufacturing process, product, or service and whether those resources are available in the Applicant's geographic area.

(6) A summary of the Applicant's plan to market the manufacturing process, product, or service. The intended market niche of the manufacturing process, product, or service shall be identified in this discussion.

(7) A description of the roles and responsibilities of private companies, nonprofit organizations, public agencies, and/or other entities involved in the implementation of the Proposal.

(e) A certification signed and dated by the Applicant's authorized representative as identified in subsection (b)(2) above. The certification shall include the following language: I hereby certify that the information provided in this Proposal is correct and represents the intended use of all sources of funds identified in the Proposal, and that I will inform the California Trade and Commerce Agency immediately of any changes in the funding proposal.

(f) Proposals submitted by nonprofit organizations shall contain two (2) attachments, labeled Exhibits "A" and "B", which include all of the following:

(1) Exhibit A:

(A) A copy of the Applicant's Federal Award application, or

(B) A copy of the Applicant's previously submitted preliminary Federal Award application, and a letter from the federal agency which indicates support for the preliminary application and a statement requesting the Applicant to submit a complete application.

(2) Exhibit B:

(A) A description of the Applicant's experience in the diffusion and/or implementation of services to improve the manufacturing process or services to facilitate the commercialization of technology; a listing of the staff who will implement the Proposal and their resumes; and an organization chart which includes those persons.

(g) Proposals submitted by California Public Agencies shall contain three (3) attachments, labeled Exhibits "A", "B", and "C" which include all of the following:

(1) Exhibit A:

(A) A copy of the Applicant's Federal Award application, or

(B) A copy of the Applicant's previously submitted preliminary Federal Award application, and a letter from the federal agency which indicates support for the preliminary application and a statement requesting the Applicant to submit a complete application.

(2) Exhibit B:

(A) A description of the Applicant's experience in the diffusion and/or implementation of Manufacturing Improvement Services and/or Technology Commercialization; a listing of the staff who will implement the Proposal and their resumes; and an organization chart which includes those persons.

(3) Exhibit C:

(A) A resolution adopted by the public agency's governing body which authorizes the submission of the Proposal to the Agency and, identifies a person authorized to represent the Applicant concerning the Grant, pursuant to subsection (b)(2) above.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15379.15 and 15379.16, Government Code.

HISTORY

1. New section filed 8–1–96 as an emergency pursuant to Government Code section 15378.99; operative 8–1–96 (Register 96, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–97 pursuant to Government Code section 15378.99 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 30).
3. New section filed 7–21–97 as an emergency; operative 7–21–97 (Register 97, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–18–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 10).
5. New section filed 3–5–98 as an emergency; operative 3–5–98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–1–98 or emergency language will be repealed by operation of law on the following day.
6. Notice of erroneous filing filed 10–8–98; purported repeal and deletion of section filed in error on 9–2–98 is null and void and text as filed with Secretary of State on 3–5–98 remains in effect uninterrupted, HISTORY 5 has been amended to show correct Certificate of Compliance date, and former HISTORY 6 has been repealed (Register 98, No. 42).
7. Certificate of Compliance as to 9–1–98 order, including amendment of section, transmitted to OAL 8–28–98 and filed 10–13–98 (Register 98, No. 42).

§ 4080.4. Proposal Eligibility.

(a) An eligible Proposal is one which meets all of the following requirements:

(1) It is submitted by a qualified Applicant as defined in Section 4080.1(b).

(2) It is the only Proposal submitted by the Applicant.

(3) If the Solicitation for a specific Grant cycle specifies that funding is tied to a specific Federal Award program, the Applicant has complied with that requirement.

(4) The Proposal is received by the deadline specified in the Solicitation.

(5) Funding for the entire Proposal is adequately identified in the Manufacturing Technology Program Budget Form described in Section 4080.3(c).

(6) The amount of funding requested from the Agency does not exceed thirty–three percent (33%) of the entire Proposal for any one year.

(7) At least thirty–three percent (33%) of the Proposal costs are provided by sources other than the federal government and/or the California Trade and Commerce Agency.

(8) One hundred percent (100%) of the funds requested from the Agency will be expended in California.

NOTE: Authority cited: Section 15378.9, Government Code. Reference: Sections 15379.15 and 15379.16, Government Code.

HISTORY

1. New section filed 8–1–96 as an emergency pursuant to Government Code section 15378.99; operative 8–1–96 (Register 96, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–97 pursuant to Government Code section 15378.99 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 30).
3. New section filed 7–21–97 as an emergency; operative 7–21–97 (Register 97, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–18–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 10).
5. New section filed 3–5–98 as an emergency; operative 3–5–98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–1–98 or emergency language will be repealed by operation of law on the following day.
6. Notice of erroneous filing filed 10–8–98; purported repeal and deletion of section filed in error on 9–2–98 is null and void and text as filed with Secretary of State on 3–5–98 remains in effect uninterrupted, HISTORY 5 has been amended to show correct Certificate of Compliance date, and former HISTORY 6 has been repealed (Register 98, No. 42).
7. Certificate of Compliance as to 9–1–98 order, including amendment of subsection (a)(1), transmitted to OAL 8–28–98 and filed 10–13–98 (Register 98, No. 42).

§ 4080.5. Funding Determination/Selection Process.

(a) A panel consisting of not less than two (2) and not more than four (4) professional full–time employees of the Agency and at least two (2) representatives of the technology development community or manufacturing community, shall score all Proposals using the criteria described in subsections (1) through (8) below. The panel shall be authorized to interview Applicants to request clarification of material submitted prior to the Solicitation Deadline, but not to request additional material.

(1) **Targeted solutions to industry needs**. More points will be given to those Proposals which include a manufacturing process, product or service that has an impact on the development of a significant segment of the manufacturing sector. More points will be given to those Proposals which: a) include a credible plan for the development of a manufacturing process, product, or service targeted to the needs of manufacturers; b) include a training component to upgrade the skills of workers or; c) lead to the creation and retention of high–value–added manufacturing jobs in California. Maximum points will be given to Proposals that clearly explain the methods used in identifying industry needs (e.g., focus groups, marketing campaigns, surveys, demographic and analytic information) and explain how this information was used to develop solutions to the problems encountered by industry. **Points 0–8.**

(2) **Project evaluation.** More points will be given to those Proposals which include a well prepared project evaluation schedule, and criteria and measures for evaluating the project. Criteria and measures may include, but need not be limited to, the number and size of firms served; the number of activities initiated by type and technical focus; workforce training activities; the jobs created or retained; the estimated annual and long–term impact within the service area; and the data regarding formation of manufacturing networks or consortia resulting from Program activity. **Points 0–8.**

(3) **Organizational capacity to fulfill the goals of the program**. More points will be given to Proposals that include a credible management plan that identifies project personnel who have specific experience related to proposed activities and relevant experience in the effective diffusion and implementation of Manufacturing Improvement Services or technology commercialization. Maximum points will be given to Proposals that clearly describe: a) the role customer feedback plays in developing the management plan and b) the Applicant's strategy for attaining the identified market niche. **Points: 0–8.**

(4) **Credible project plan**. More points will be given to those Proposals which include a credible plan for the development of the project which includes: a) a thorough description of the opportunities and impediments to the successful diffusion and implementation of manufacturing improvement services within the Applicant's region and throughout the state, b) a thorough understanding of and capacity for production, capitalization, engineering, and research and development, and c) a concrete and credible management plan that will result in continued operation or commercial viability beyond the public funding cycle. **Points: 0–8.**

(5) **Likelihood of Federal Award**: More points will be given to those Proposals which use the Grant as matching funds for a Federal Award. Maximum points will be given to those Proposals which indicate evidence of the receipt of a Federal Award requiring matching funds. **Points: 0–5.**

(6) **Sources of funding**: More points will be given to those Proposals which indicate significant funds from sources other than state and federal

agencies. Maximum points will be given to those Proposals showing a diverse source of funding including private sector sources, including In–kind contributions. **Points: 0–5.**

(7) **Partnering with other agencies and organizations**. More points will be given to those Proposals which increase the effectiveness of the diffusion and implementation of manufacturing improvement services or, accelerate the commercialization of the project by enlisting the assistance and cooperation of other agencies and organizations. Maximum points will be given to those proposals that identify all partners and their respective roles. Examples of partners include, but are not limited to: the Regional Technology Alliance, the California Space and Technology Alliance, the Employment Training Panel, regional educational and business development organizations, and other public sector, nonprofit, and private manufacturing support programs. **Points: 0–4.**

(8) **Diversity of Grant awards**. More points will be given to those Proposals submitted by Applicants who have not received a Grant or, to those Proposals that will be implemented in geographic regions in which Applicants have not received a Grant. **Points: 0–4.**

(b) Proposals which receive between thirty (30) and fifty (50) points shall be considered for funding by the Agency. Based on negotiations pursuant to subsections 4080.2(d) or (e), the Agency shall award Grants to the Applicant(s) receiving the highest scores.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15379.15 and 15379.16, Government Code.

HISTORY

1. New section filed 8–1–96 as an emergency pursuant to Government Code section 15378.99; operative 8–1–96 (Register 96, No. 31). A Certificate of Compliance must be transmitted to OAL by 1–28–97 pursuant to Government Code section 15378.99 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 97, No. 30).
3. New section filed 7–21–97 as an emergency; operative 7–21–97 (Register 97, No. 30). A Certificate of Compliance must be transmitted to OAL by 11–18–97 or emergency language will be repealed by operation of law on the following day.
4. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 10).
5. New section filed 3–5–98 as an emergency; operative 3–5–98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–1–98 or emergency language will be repealed by operation of law on the following day.
6. Notice of erroneous filing filed 10–8–98; purported repeal and deletion of section filed in error on 9–2–98 is null and void and text as filed with Secretary of State on 3–5–98 remains in effect uninterrupted, HISTORY 5 has been amended to show correct Certificate of Compliance date, and former HISTORY 6 has been repealed (Register 98, No. 42).
7. Certificate of Compliance as to 9–1–98 order, including amendment of subsection (b), transmitted to OAL 8–28–98 and filed 10–13–98 (Register 98, No. 42).

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§ 4081. Definitions.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New chapter 6.57 (sections 4081–4081.8) and section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect amending subsection (j)(1) filed 10–31–2001 pursuant to section 100, title 1, California Code of Regulations (Register 2001, No. 44).
5. Change without regulatory effect repealing chapter (sections 4081–4081.8) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.1. Proposal Process.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order, including amendment of subsection (a), transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.2. Proposal Content.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order, including amendment of subsection (a)(1), transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.3. Proposal Form.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order, including amendment of section heading and first paragraph, transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.4. Budget Form.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.5. Proposal Body.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.6. Proposal Attachments.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.7. Proposal Eligibility.

NOTE: Authority cited: Section 15378.9, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order, including amendment of subsection (e), transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4081.8. Funding Determination/Selection Process.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5(b)(2) and 15379.14, Government Code.

HISTORY

1. New section filed 12–18–2000 as an emergency; operative 12–18–2000 (Register 2001, No. 16). Pursuant to Government Code section 15378.99 a Certificate of Compliance must be transmitted to OAL by 6–18–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 16).
3. Certificate of Compliance as to 12–18–2000 order, including amendment of subsections (a)–(g), transmitted to OAL 5–3–2001 and filed 6–11–2001 (Register 2001, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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Chapter 6.58. Defense Retention Grant Program

§ 4083. Definitions.

The following definitions shall apply to the regulation contained in this chapter:

(a) "Agency" means the California Technology, Trade and Commerce Agency.

(b) "Applicant" means a California city, county, city and county, a joint powers authority between one or more cities and/or counties, or a Special District of city or county that has an active military base within its jurisdiction and has applied to the Agency for a Grant.

(c) "Application" means the information and attachments, described in sections 4083.3, 4083.4, and 4083.5.

(d) "Authorized Representative" means the person authorized by the Applicant's governing body to execute the section 4083.1(d) Grant agreement and any and all amendments or revisions thereto.

(e) "Base Retention" means the programs and strategies undertaken to protect and promote the necessity of an active military base located in an Applicant's jurisdiction.

(f) "Full Time Employee" means one or more persons working one thousand, seven hundred fifty (1750) hours (or more) in a twelve (12) month period.

(g) "Grant" means an award of California Defense Retention Grant funding pursuant to this chapter that need not be repaid.

(h) "In–Kind" means resources other than money that is provided by the Applicant, private companies, nonprofit organizations, public agencies, and/or other entities involved in the implementation of the Plan. Examples of In–Kind Support include equipment; supplies; space and facilities; managerial, secretarial, financial, and other administrative services; and technical training.

(i) "Special District" means a unit of local government.

NOTE: Authority cited: Sections 15346.10 and 15346.12, Government Code. Reference: Sections 15346, 15346.1, 15346.10 and 15346.12, Government Code.

HISTORY

1. New chapter 6.58 (sections 4083–4083.5) and section filed 2–7–2001 as an emergency; operative 2–7–2001 (Register 2001, No. 6). Pursuant to Government Code section 15346.12, a Certificate of Compliance must be transmitted to OAL by 8–6–2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–7–2001 order, including amendment of section, transmitted to OAL 7–25–2001 and filed 8–17–2001 (Register 2001, No. 33).

§ 4083.1. Application Process.

(a) The Agency shall send a letter announcing the availability of Grants, "Solicitation", to all California cities, counties, cities and counties that have an active military base within its jurisdiction, and to any person requesting information about the California Base Retention Grant program. The Solicitation shall include a description of the Application process and the Application deadline. The Application deadline shall be no later than thirty (30) calendar days following the mailing of the Solicitation. Interested parties may request copies of the Solicitation in writing, via facsimile, or by electronic mail.

(b) Not later than the deadline described in the subsection (a) Solicitation, each Applicant shall submit an original and four (4) copies of a completed Application, and an electronic copy of all documents on diskette, if available, to the Agency address listed in the Solicitation.

(c) Not later than fifteen (15) business days following the deadline described in the subsection (a) Solicitation, the Agency shall mail a letter, Notice of Completion and Eligibility, to each Applicant that submitted an incomplete or ineligible Application. If the Application is incomplete, the Notice of Completion and Eligibility shall describe the missing or incomplete information. The Applicant shall provide the missing or incomplete information to the Agency not later than 5 p.m., ten (10) business days following the mailing of the Notice of Completion and Eligibility. The Agency shall only accept materials directly related to the issue(s) described in the Notice of Completion and Eligibility. If the Application is ineligible, the Notice of Completion and Eligibility shall explain why the Application does not meet the requirements described in section 4083.2. Applicants that submit Applications that do not meet the requirements described in section 4083.2 shall not have an opportunity to submit additional information and shall be disqualified from further review.

(d) Not later than sixty (60) calendar days following the deadline described in subsection (a) Solicitation, the Agency shall mail to each Applicant that submitted an eligible Application either a notice disapproving the funding request or a letter of conditional grant award based upon the section 4083.4(h) funding determination. The notice disapproving the funding request shall explain why the Application will not be funded. The letter of conditional grant award shall describe the amount of the Applicant's Grant and include a statement indicating disbursement of the Grant is conditioned upon execution of a Grant agreement between the Applicant and the Agency.

NOTE: Authority cited: Sections 15346.10 and 15346.12, Government Code. Reference: Sections 15346, 15346.1, 15346.10 and 15346.12, Government Code.

HISTORY

1. New section filed 2–7–2001 as an emergency; operative 2–7–2001 (Register 2001, No. 6). Pursuant to Government Code section 15346.12, a Certificate of Compliance must be transmitted to OAL by 8–6–2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–7–2001 order, including amendment of section, transmitted to OAL 7–25–2001 and filed 8–17–2001 (Register 2001, No. 33).

§ 4083.2. Eligible Application.

An eligible Application is one that meets all of the following requirements:

(a) It is submitted by an eligible Applicant, as defined in Section 4083(b).

(b) The Application is received by the deadline specified in the Solicitation as provided in section 4083.1(a).

(c) The Application addresses Base Retention programs within the Applicant's jurisdiction.

(d) The Applicant has not been previously awarded two (2) or more Defense Retention Grants.

(e) The amount of Grant funds requested is at least ten thousand dollars ($10,000).

(f) At least fifty percent (50%) of the total project cost of developing the Base Retention strategy described in the Application is provided by sources other than the California Technology, Trade and Commerce Agency, as identified in the budget form described in section 4083.5(d).

NOTE: Authority cited: Sections 15346.10 and 15346.12, Government Code. Reference: Sections 15346, 15346.1, 15346.10 and 15346.12, Government Code.

HISTORY

1. New section filed 2–7–2001 as an emergency; operative 2–7–2001 (Register 2001, No. 6). Pursuant to Government Code section 15346.12, a Certificate of Compliance must be transmitted to OAL by 8–6–2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–7–2001 order, including amendment of section, transmitted to OAL 7–25–2001 and filed 8–17–2001 (Register 2001, No. 33).

§ 4083.3. Application. General Information.

The General Information Section of the application shall contain the following information.

(a) Applicant Information

(1) The Applicant's name, address, county, telephone and facsimile numbers, e–mail address (if applicable), and federal tax identification number.

(2) The name and title of the Applicant's Authorized Representative and the Authorized Representative's address and telephone and facsimile number, if different than subsection (a)(1).

(3) The name and title of the Applicant's contact person and the contact person's address, and telephone and facsimile number, if different than subsection (a)(1).

(4) A description of the problem the proposal addresses and how the project will remediate the local and regional economic impacts of the defense–related industry downsizing, closing or realigning military bases.

(b) Funding Information

(1) The amount of Grant funds requested.

(2) If appropriate, other state and/or federal funds available for the development of the Defense Retention plan described in the Application.

(3) The amount of in–kind and cash contributions to be provided by the Applicant.

(4) Provide a statement summarizing the Applicant's annual total budget for each of the last three years. The summary shall include all sources of funds, total expenditures, any surplus or reserve contributions, and any voluntary unscheduled payment for debt reduction.

NOTE: Authority cited: Sections 15346.10 and 15346.12, Government Code. Reference: Sections 15346, 15346.1, 15346.10 and 15346.12, Government Code.

HISTORY

1. New section filed 2–7–2001 as an emergency; operative 2–7–2001 (Register 2001, No. 6). Pursuant to Government Code section 15346.12, a Certificate of Compliance must be transmitted to OAL by 8–6–2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–7–2001 order, including amendment of section, transmitted to OAL 7–25–2001 and filed 8–17–2001 (Register 2001, No. 33).

§ 4083.4. Application. Scored Information.

The Scored Information Section shall contain the following:

(a) Lead Agency (0 to 5 points): The description of the Lead Agency shall include: the name of the local agency that will be responsible for administering the Grant ("Lead Agency"), a statement that the Lead Agency meets the requirements of the definition of Applicant contained in section 4083(b), and the Lead Agency's experience in collaborating with military bases located in the Applicant's jurisdiction.

(b) Award Frequency (0 to 5 points): The number of Grants awarded to the Applicant by the Agency.

(1) Five (5) points shall be awarded to Applicants which have never received a Grant; three (3) points shall be awarded to Applicants which have received one (1) prior Grant; and zero (0) points shall be awarded to Applicants which have received two (2) or more prior Grants.

(2) Applicants that submit more than one (1) funding request in a Grant cycle shall prioritize each Application submitted, based upon the needs which exist in the Applicant's jurisdiction. If the Application with highest priority is selected for funding, the Agency shall lower the scores of the other Applications submitted by the Applicant pursuant to the procedures described in subsection (b)(1).

(c) Regional Collaboration (0 to 5 points): Five (5) points shall be awarded to Applications that address the retention of two (2) or more military bases. Zero (0) points will be awarded to Applications that address the retention of only one (1) military base.

(d) Plan Description (0 to 10 points):

(1) A description of the short– and long–term goals of the proposed Base Retention plan.

(2) A description of how the proposed plan relates to and is different from previously prepared plans or previously implemented projects that address Base Retention within the Applicant's jurisdiction.

(3) A list of the organizations that will be involved in implementing the proposed plan.

(4) A description of previous and current outreach efforts directed toward businesses and organizations in the Applicant's jurisdiction that have been adversely affected by A) the closure of a military base or relocation of some of the base's activities to another site and/or B) the transition of defense industries (and suppliers to those industries) from defense–related production to production for civilian markets.

(5) The number and type of full–time jobs that are expected to be directly retained or created by the plan during the three (3) year period following the award of the Grant. This description shall include an explanation of how this estimate was derived, identify the amount of Grant funding necessary to retain or create each position, and list the dollar amount and source of any other funding the Applicant will use for job retention or creation.

(6) Other proposals for Base Retention in the Applicant's jurisdiction.

(e) Need (0 to 10 points): The description of the necessity of the Grant shall include the following:

(1) The Applicant's efforts to obtain funding for the proposed plan from sources other than the Agency.

(2) The benefits of having an active military base within the Applicant's jurisdiction including: the percentage of jobs within the Applicant's jurisdiction derived from the military facility (using the categories contained in the current version of the North American Industry Classification System) and reductions in jobs, community services, and revenues that will occur if the military base is not retained. This description shall also include the potential impact to the Applicant's jurisdiction if the Grant request is denied.

(f) Regional Impact (0 to 10 points): How the proposed plan will directly assist the Applicant in addressing local and regional economic needs. Indicate how the proposed plan will be linked, through shared initiatives or collaborative activities, to regional business and community development resources for the purpose of addressing regional and local aspects of base retention. Examples of community development resources include, but are not limited to: community colleges, economic development groups, chambers of commerce, professional or industrial associations, regional marketing associations, Team California (a cooperative network of public and private economic development leaders that bring together resources and expertise from organizations throughout the state to promote business investment and job creation), or the Defense Marketing Association (a statewide advertising collaborative initiated by the Agency to combat the devastating loss of jobs caused by the closure and downsizing of major military bases and numerous defense facilities in California).

(g) Achievements (0 to 10 points). Indicate what has been accomplished to date to advance the retention of military bases in the Applicant's jurisdiction including, but not limited to, a description of how local, federal, and state grants previously awarded to the Applicant for Base Retention were used and the efficiency and effectiveness of the projects funded with those grants.

(h) A panel consisting of not fewer than three (3) nor more than six (6) professional employees of the Agency shall evaluate all eligible Applications based upon the categories and point values described in subsections (a) through (g). Applications receiving a total score of twenty–five (25) or more points shall be ranked and funded in descending order by number of points scored until all available funds have been committed. Applications scoring below twenty–five (25) points shall be disqualified from current consideration but may be modified and resubmitted during a subsequent funding cycle. In the event of a tie score between two or more Applicants whose total request for matching funds exceeds the remaining Grant funds available, the Agency shall award the Grant to the Applicant that received the most points pursuant to the subsection 4083.4(e) criterion. If both Applicants received the same number of points on the subsection 4083.4(e) criterion, the Agency shall award the Grant to the Applicant that received the most points pursuant to subsection 4083.4(f) criterion.

NOTE: Authority cited: Sections 15346.10 and 15346.12, Government Code. Reference: Sections 15346, 15346.1, 15346.10 and 15346.12, Government Code.

HISTORY

1. New section filed 2–7–2001 as an emergency; operative 2–7–2001 (Register 2001, No. 6). Pursuant to Government Code section 15346.12, a Certificate of Compliance must be transmitted to OAL by 8–6–2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–7–2001 order, including amendment of section heading and section, transmitted to OAL 7–25–2001 and filed 8–17–2001 (Register 2001, No. 33).

§ 4083.5. Application. Exhibits.

The Application shall contain the following exhibits:

(a) Attach as Exhibit–A a resolution adopted by the governing body of the Applicant authorizing the Applicant to submit the Application to

the Agency and specifying a person authorized to execute the Grant contract and any and all amendments or revisions thereto (the "Authorized Representative").

(b) Attach as Exhibit–B both a description of the organizational structure for administering the Grant and managing the proposed project, and the resume and/or job description of the person who will administer the project.

(c) Attach as Exhibit–C a detailed scope–of work for the activities to be funded by the Grant.

(d) Attach as Exhibit–D, the Defense Retention Grant Budget Form (new, 5/15/2001), incorporated by reference.

(e) Attach as Exhibit–E duty statements and position descriptions for any positions to be paid for by the Grant.

(f) Attach as Exhibit–F copies of any and all consultant contracts or personal service agreements negotiated or under negotiation as part of the proposed project.

(g) Attach as Exhibit–G a timeline identifying the tasks to be undertaken as part of the scope–of–work and their anticipated completion dates in relation to the initiation of the proposed project.

(h) Attach as Exhibit–H a certificate signed and dated by the Authorized Representative described above in subsection (a) stating the following: "I hereby certify under penalty of perjury under the laws of the State of California that the information provided in this Application is correct and represents the intended use of all sources of funds identified in the Application, and that I will inform the Office of Military Base Retention and Reuse of the California Technology, Trade and Commerce Agency, in writing, within ten (10) days of any changes in the funding proposal prior to awarding of the grant."

NOTE: Authority cited: Sections 15346.10 and 15346.12, Government Code. Reference: Sections 15346, 15346.1, 15346.10 and 15346.12, Government Code.

HISTORY

1. New section filed 2–7–2001 as an emergency; operative 2–7–2001 (Register 2001, No. 6). Pursuant to Government Code section 15346.12, a Certificate of Compliance must be transmitted to OAL by 8–6–2001 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2–7–2001 order, including amendment of section, transmitted to OAL 7–25–2001 and filed 8–17–2001 (Register 2001, No. 33).

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Chapter 6.7. Conflict of Interest Code

§ 4200. General Provisions.

CONFLICT OF INTEREST CODE FOR THE CALIFORNIA TRADE AND COMMERCE AGENCY

The Political Reform Act of 1974 (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict of interest codes. The Fair Political Practices Commission has adopted a regulation (2 California Code of Regulations Section 18730) which contains the terms of a standard conflict of interest code, which can be incorporated by reference in an agency's code. After public notice and hearing it may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference into Section 4200 (a copy of section 18730 is attached hereto). Section 4200 and the attached Appendixes, designating officials and employees and establishing disclosure categories, shall constitute the conflict of interest code of the California Trade and Commerce Agency, "Agency".

Designated employees identified in Appendix A, shall file statements of economic interests with the Agency. Upon receipt of the statement of the Secretary of the Agency, "Secretary", the Agency shall make and retain a copy and forward the original of this statement to the Fair Political Practices Commission. Statements for all other designated employees will be retained by the Agency.

PROHIBITION ON HONORARIA

Board members and designated employees of the Agency are prohibited from accepting any honorarium from any source which the board member or employee would be required to report as a source of income, loans, or gifts on his or her statement of economic interests.

"Honorarium" means, except as provided below, any payment made in consideration for any speech given, article published, or attendance at any public or private conference, convention, meeting, social event, meal, or like gathering.

"Honorarium" does not include earned income for personal services which are customarily provided in connection with the practice of a bona fide business, trade, or profession, such as teaching, practicing law, medicine, insurance, real estate, banking, or building contracting, unless the sole or predominant activity of the business, trade, or profession is making speeches. Honorarium also does not include income for personal services which are unconnected to the scope of the work of the employee's employment with the Agency.

LIMIT ON GIFTS

Board members and designated employees of the Agency are prohibited from receiving gifts with a total value of more than the amount specified in 2 California Code of Regulations, Section 18730 from any single source which the board member or designated employee is required to report as a source of income, loans, or gifts on his or her statement of economic interests.

The limit on gifts specified in 2 California Code of Regulations, Section 18730 does not apply to the following:

(1) Payments, advances, or reimbursements for travel and related lodging and subsistence permitted by Government Code Section 89506;

(2) Wedding gifts and gifts exchanged between individuals on birthdays, holidays, and other similar occasions, provided that the gifts exchanged are not substantially disproportionate in value; and

(3) The general exceptions provided in Government Code Section 82028(b) and Title 10, Chapter 7, Article 8 of California Code of Regulations.

Appendix—A

Designated Employees

It has been determined that the following positions have responsibilities for the making of decisions or for participating in the making of decisions which may have a foreseeable, material effect on financial interests. The designated employees shall disclose in their statement of economic interest those financial interests which are of the kind described in the disclosure category to which they are assigned in Appendix B.

Designated Positions:

1. All classifications at or above the level of Undersecretary (disclosure categories I, II, and III).
2. All career executive assignment classifications (disclosure categories I, II, and III).
3. All exempt appointees (disclosure categories I, II, and III).
4. All legal classifications (disclosure categories I, II, and III).
5. All administrative classifications at or above the associate level including fiscal, management, information technology (disclosure categories I and II).
6. All Business Service Office classifications at or above the level of Business Service Officer II (disclosure categories I and II).
7. All non–administrative classifications at or above associate the level including Staff Services, Tourism Specialist, Development Specialist, Information Officer, Loan Officer, Research Analyst, Research Program Specialist, and Motion Picture Production Analyst (disclosure categories I, II, and III).
8. All consultants. As used in this section, a "consultant" is a natural person who provides, under contract, information, advice, recommendation or counsel to the Agency. If the Agency hires an entity to do consulting work, the natural person(s) selected by the entity to provide the consulting services shall be covered by this section. The term consultant does not include a person who: 1) conducts research and arrives at conclusions with respect to his or her rendition of information, advice, recommendation or counsel independent of the control and direction of the Agency or any Agency official, other than normal contract monitoring; and 2) possesses no authority with respect to any Agency decision beyond the rendition of information, advice, recommendation or counsel (disclosure categories I, II, and III).

   Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation:

   The Secretary, or his or her designee(s), may determine in writing that a particular consultant is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Secretary's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code.

Appendix—B

Disclosure Categories

Category I: Individuals assigned to this category shall disclose all investments and business positions in business entities, interests in real property, and sources of income as well as business positions in and income from nonprofit organizations of the type which may be recipients of contracts, grants, loans, or loan guarantees from the California Trade and Commerce Agency.

Category II: Individuals assigned to this category shall disclose all investments and business position in, and income from any business entity of the type to contract with the California Trade and Commerce Agency to provide equipment, supplies, or services or to receive services, grants, loans or loan guarantees, or participate in any of the programs administered by the Agency.

Category III: Individuals assigned to this category shall disclose all investments and business positions in, and income from, any business entity of the type to participate in any of the programs administered by the California Trade and Commerce Agency or which engages in real estate transactions (including all interest in real property zoned commercial or industrial), construction development, investment brokering, or similar activities.

HISTORY

1. New section and Appendix filed 5–4–92; operative 6–3–92. Approved by Fair Political Practices Commission 3–9–92 (Register 92, No. 20).
2. Editorial correction inserting chapter heading (Register 92, No. 28).
3. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Amendment of section and repealer and new Appendices A and B filed 12–11–2000; operative 1–10–2001. Approved by Fair Political Practices Commission 9–29–2000 (Register 2000, No. 50).

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Chapter 6.71. Dry Cleaning Plant Registration

§ 4300. Definitions.

NOTE: Authority cited: Section 15372.21, Government Code. Reference: Sections 15372.11, 15372.13, 15372.14, 15372.16 and 15372.19, Government Code.

HISTORY

1. New chapter 6.71 (sections 4300–4305) filed 12–28–92 as an emergency; operative 12–28–92 (Register 93, No. 1). A Certificate of Compliance must be transmitted to OAL 6–26–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance including amendment of section transmitted to OAL 6–14–93 and filed 7–27–93 (Register 93, No. 31).
3. Editorial correction of HISTORY 1 (Register 93, No. 31).
4. Change without regulatory effect amending subsections (e) and (i) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing chapter (sections 4300–4305) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4301. Application Form.

NOTE: Authority cited: Section 15372.21, Government Code. Reference: Sections 15372.14, 15372.17 and 15372.18, Government Code.

HISTORY

1. New section filed 12–28–92 as an emergency; operative 12–28–92 (Register 93, No. 1). A Certificate of Compliance must be transmitted to OAL 6–26–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance transmitted to OAL 6–14–93 and filed 7–27–93 (Register 93, No. 31).
3. Editorial correction of HISTORY 1 (Register 93, No. 31).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4302. Registration Process.

NOTE: Authority cited: Section 15372.21, Government Code. Reference: Sections 15372.12 and 15372.13, Government Code.

HISTORY

1. New section filed 12–28–92 as an emergency; operative 12–28–92 (Register 93, No. 1). A Certificate of Compliance must be transmitted to OAL 6–26–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance including amendment of subsection (b) transmitted to OAL 6–14–93 and filed 7–27–93 (Register 93, No. 31).
3. Editorial correction of HISTORY 1 (Register 93, No. 31).
4. Change without regulatory effect amending subsections (b)–(c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4303. Registration.

NOTE: Authority cited: Section 15372.21, Government Code. Reference: Sections 15372.12, 15372.13, 15372.18 and 15372.19, Government Code.

HISTORY

1. New section filed 12–28–92 as an emergency; operative 12–28–92 (Register 93, No. 1). A Certificate of Compliance must be transmitted to OAL 6–26–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance including amendment of subsection (a) transmitted to OAL 6–14–93 and filed 7–27–93 (Register 93, No. 31).
3. Editorial correction of HISTORY 1 (Register 93, No. 31).
4. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4304. Guaranty.

NOTE: Authority cited: Section 15372.21, Government Code. Reference: Section 15372.16, Government Code.

HISTORY

1. New section filed 12–28–92 as an emergency; operative 12–28–92 (Register 93, No. 1). A Certificate of Compliance must be transmitted to OAL 6–26–93 or emergency language will be repealed by operation of law on the following day.
2. Certified of Compliance including amendment of section heading and text transmitted to OAL 6–14–93 and filed 7–27–93 (Register 93, No. 31).
3. Editorial correction of HISTORY 1 (Register 93, No. 31).
4. Change without regulatory effect amending subsections (c)–(d) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4305. Bond and Security.

NOTE: Authority cited: Section 15372.21, Government Code. Reference: Section 15372.16, Government Code.

HISTORY

1. New section filed 12–28–92 as an emergency; operative 12–28–92 (Register 93, No. 1). A Certificate of Compliance must be transmitted to OAL 6–26–93 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance including amendment of section heading and text transmitted to OAL 6–14–93 and filed 7–27–93 (Register 93, No. 31).
3. Editorial correction of HISTORY 1 (Register 93, No. 31).
4. Change without regulatory effect amending subsections (a) and (e) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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Title 10. Investment

Chapter 6.75. Incubator Grants

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Chapter 6.75. Incubator Grants

§ 4550. Definitions.

NOTE: Authority cited: Section 6, Chapter 1039, Statutes of 1996. Reference: Section 15339.2, Government Code.

HISTORY

1. New chapter 6.75 (sections 4550–4553) and section filed 2–6–97 as an emergency; operative 2–6–97 (Register 97, No. 6). A Certificate of Compliance must be transmitted to OAL by 8–6–97 pursuant to section 6, chapter 1039, Stats '96 or emergency language will be repealed by operation of law on the following day.
2. New chapter 6.75 (sections 4550–4553) and section refiled 4–14–97 as an emergency; operative 4–14–97 (Register 97, No. 16). A Certificate of Compliance must be transmitted to OAL by 10–13–97 pursuant to section 6, chapter 1039, statutes of 1996, or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4–14–97 order, including amendment of subsection (e), transmitted to OAL 8–27–97 and filed 10–8–97 (Register 97, No. 41).
4. Change without regulatory effect repealing chapter (sections 4550–4553) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4551. Application Content.

NOTE: Authority cited: Section 6, Chapter 1039, Statutes of 1996. Reference: Section 15339.2, Government Code.

HISTORY

1. New section filed 2–6–97 as an emergency; operative 2–6–97 (Register 97, No. 6). A Certificate of Compliance must be transmitted to OAL by 8–6–97 pursuant to section 6, chapter 1039, Stats '96 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–14–97 as an emergency; operative 4–14–97 (Register 97, No. 16). A Certificate of Compliance must be transmitted to OAL by 10–13–97 pursuant to section 6, chapter 1039, statutes of 1996, or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4–14–97 order, including amendment of subsections (a), (b), (c)(1)(B) and (c)(2)(A), transmitted to OAL 8–27–97 and filed 10–8–97 (Register 97, No. 41).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4552. Application Process.

NOTE: Authority cited: Section 6, Chapter 1039, Statutes of 1996. Reference: Section 15339.2, Government Code.

HISTORY

1. New section filed 2–6–97 as an emergency; operative 2–6–97 (Register 97, No. 6). A Certificate of Compliance must be transmitted to OAL by 8–6–97 pursuant to section 6, chapter 1039, Stats '96 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–14–97 as an emergency, including amendment of subsections (a), (b) and (c)(4); operative 4–14–97 (Register 97, No. 16). A Certificate of Compliance must be transmitted to OAL by 10–13–97 pursuant to section 6, chapter 1039, statutes of 1996, or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4–14–97 order, including amendment of subsections (a), (b) and (g), transmitted to OAL 8–27–97 and filed 10–8–97 (Register 97, No. 41).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4553. Scoring Application.

NOTE: Authority cited: Section 6, Chapter 1039, Statutes of 1996. Reference: Section 15339.2, Government Code.

HISTORY

1. New section filed 2–6–97 as an emergency; operative 2–6–97 (Register 97, No. 6). A Certificate of Compliance must be transmitted to OAL by 8–6–97 pursuant to section 6, chapter 1039, Stats '96 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–14–97 as an emergency; operative 4–14–97 (Register 97, No. 16). A Certificate of Compliance must be transmitted to OAL by 10–13–97 pursuant to section 6, chapter 1039, statutes of 1996, or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4–14–97 order, including amendment of section, transmitted to OAL 8–27–97 and filed 10–8–97 (Register 97, No. 41).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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§ 4610. Definitions.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. New chapter 6.81 and renumbering of former section 4010 to section 4610 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect amending subsection (p) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Change without regulatory effect repealing chapter (sections 4610–4619) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4611. Eligibility.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4011 to section 4611 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4612. Loan Terms.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4012 to section 4612 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4613. Application Availability, Submission and Contractor Review.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4013 to section 4613 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect amending subsection (a) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4614. Application Content.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4014 to section 4614 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4615. Environmental Audit.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4015 to section 4615 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4616. Office Recommendation.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4016 to section 4616 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4617. Authority Approval.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4017 to section 4617 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect amending subsection (e)(6) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4618. Loan Disbursement.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Renumbering of former section 4018 to section 4618 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 4619. Eligibility for a Guarantee to a Farm Enterprise.

NOTE: Authority cited: Section 14075(b), Corporations Code. Reference: Sections 14075(a), Corporations Code.

HISTORY

1. New section filed 3–22–91 as an emergency; operative 3–22–91 (Register 91, No. 16). A Certificate of Compliance must be transmitted to OAL by 7–22–91 or emergency language will be repealed by operation of law on the following day.
2. Repealer filed 3–19–92 as an emergency; operative 3–19–92 (Register 92, No. 15). A Certificate of Compliance must be transmitted to OAL 7–17–92 or emergency language will be repealed by operation of law on the following day.
3. Renumbering of former section 4019 to section 4619 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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§ 4620. Environmental Assessment.

NOTE: Authority cited: Section 44520(b), Health and Safety Code. Reference: Sections 44533(b) and 44548(c), Health and Safety Code; and Section 15335, Government Code.

HISTORY

1. Repealer of chapter 6.52 and new chapter 6.82 including renumbering of former section 4020 to section 4620 filed 6–2–92; operative 6–2–92 (Register 92, No. 24).
2. Certificate of Compliance as to 3–19–92 order transmitted to OAL 7–30–92 and filed 9–9–92 (Register 92, No. 37).
3. Change without regulatory effect repealing chapter (section 4620) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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Title 10. Investment

Chapter 7. Business, Transportation and Housing Agency: Small Business Loans and Guarantees

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Chapter 7. Business, Transportation and Housing Agency: Small Business Loans and Guarantees

Article 1. Definitions

Article 2. Loan Guarantees

§ 5000. Definitions.

In addition to the definitions contained in Corporations Code section 14010, the following supplemental definitions shall govern the construction of this chapter:

(a) "Allocation" and "Allocated" mean the process of disbursing appropriated Expansion Fund moneys to a Corporation's trust fund account, except for Allocations for areas affected by a state of emergency or a disaster, which shall be disbursed pursuant to Corporations Code section 14037.6. The Allocation process is described in subsections 5070(a) through (c).

(b) "Application" means all of the information required by a Lender or Surety in order to determine whether to offer a Borrower a Loan, or a Principal a Bond.

(c) "Bond" means an obligation in writing concerning the construction or service work of Principal, binding the Surety to pay certain sums upon the occurrence of specified events connected to the payment of sums due by the Principal pursuant to a payment bond, and the obligation to complete the construction or service work, pursuant to a performance bond.

(d) "Bond Guarantee" means a Guarantee which promises the payment of all or a portion of a Claim.

(e) "Bond Line" means a specified amount and term of Bond Guarantee authority which Principal is authorized to apply against any Bond with a specified Surety during the term of the Bond Line.

(f) "Borrower" means an eligible business which has received a commitment for a Loan, or has prepared an Application. In order to be an "eligible business, the business must be either:

(1) a "Small Business" as defined in part 121 of chapter 1 of title 13 of the Code of Federal Regulations as amended;

(2) a Farm Enterprise; or

(3) a business located within an enterprise zone, as defined in subdivision (d) of section 7072 of the Government Code.

(g) "Claim" means a request for payment by a Surety made to a Corporation because of Surety's Loss under a Bond or ILOC secured by a Guarantee, pursuant to section 5010 or 5015.

(h) "Collateral" means those personal and business assets of the Borrower or Principal and guarantor subject to a lien under the Loan or Bond.

(i) "Collection Guarantee" means a Guarantee of a specified percentage of net Loan principal and ninety (90) days interest at the same percentage. "Net Loan principal" as used in this paragraph means the amount of Loan principal remaining outstanding after the Lender has fully complied with the collection procedures in section 5004.

(j) "Corporate Contract" means a contract executed exclusively between the Agency and any individual Corporation.

(k) "Default" means either a delinquency which has not been cured within ninety (90) days, or that the Borrower is in bankruptcy.

(*l*) "Delinquency" means the failure of the Borrower to make any payment when due, pursuant to the terms of the Loan, except for any principal payment due at the maturity of the Loan.

(m) "Demand" means a request for payment by a Lender to a Corporation pursuant to section 5003 or by a Surety to a Corporation pursuant to section 5015.

(n) "Encumbrance" means a Corporation's outstanding Guarantee balance plus the Farm Loan balance on all Guarantees and Farm Loans in effect. The Guarantee effective date is the date of the executed Guarantee agreement.

(1) The Guarantee balance is calculated as follows:

(A) For a Term Loan, the Guarantee balance is calculated as the outstanding loan balance times the Guarantee percentage.

(B) For a Line of Credit Loan, the Guarantee balance is calculated as the amount of the line times the Guarantee percentage.

(2) The Farm Loan balance is calculated as 40% of the outstanding Loan balance loaned from a trust fund account for the purpose of Farm Loans.

(o) "Farm Enterprise" means the business of producing crops, livestock products and aquatic organisms through the utilization and management of land, water, labor, capital, and basic raw materials including seed, feed, fertilizer, and fuel.

(p) "Farm Loan" means a loan as defined in section 5110(g).

(q) "Guarantee" means a written agreement to warrant the repayment of a portion of a Loan or payment of all or a portion of a Claim, with repayment from the Corporation's trust fund account. Every Guarantee of a Loan shall be either a Collection Guarantee or Loan Guarantee.

(r) "Goals" means the number of Loans a Corporation expects to Guarantee and the number of Farm Loans a Corporation expects to make during a specified period of time. A Corporation's Goals shall be specified in the Corporate Contract and shall be used by the Agency to establish the maximum amount of Expansion Fund moneys to be allocated to a Corporation.

(s) "Holder" means the person or entity purchasing up to ninety percent (90%) of the Loan pursuant to article 3.

(t) "ILOC" means an irrevocable letter of credit issued by a Corporation as Collateral for a Bond and which complies with the requirements set forth in section 5014.

(u) "Law" means the California Small Business Financial Development Corporation Law.

(v) "Lender" means a banking organization, including national banks and trust companies and state chartered commercial banks, savings and loan associations, credit unions, state insurance companies, mutual insurance companies, and other banking, lending, retirement, and insurance organizations, authorized to conduct business in California.

(w) "Leverage" means the calculation where the numerator is the Encumbrance and the denominator is the Corporation's trust fund account balance.

(x) "Line of Credit Loan" means a Loan for a term not to exceed one year, except for a Farm Enterprise Loan which shall have a term not to exceed two years, where the minimum repayment is structured as interest only during the term of the Loan.

(y) "Loan" means a Loan or supplier credit extended by a Lender to a Borrower, which is guaranteed pursuant to section 5002, and which is either a Term Loan, a Micro Loan, a Line of Credit Loan, or a Revolver Loan.

(z) "Loan Guarantee" means a Guarantee of a specified percentage of Loan principal and ninety (90) days interest at the same percentage.

(aa) "Loss" means any net monetary damages incurred by a Surety arising out of a Claim, or in pursuing the Surety's rights under the indemnity agreement. As used in this subsection, "net monetary damages" means loss payments, completion costs, reasonable attorneys fees, and reasonable out of pocket consultant fees, costs, and expenses, minus amounts recovered by the Surety from any source, including Collateral. The determination of such loss will take into account amounts recovered, but excluding reinsurance. As used herein, "indemnity agreement" means the written agreement whereby Principal agrees to reimburse Surety for any Loss.

(bb) "Master Agreement" means a contract executed between the Agency and one or more Corporations to implement the operating provisions of any of the programs established under the Law.

(cc) "Micro Loan" means a Term Loan not to exceed twenty–five thousand dollars.

(dd) "Multi–party Contract" means a contract executed between the Agency and one or more Corporations for the payment of a fee to the Corporations for completing Loan Guarantees and Farm Loans in excess of the Goals described in each Corporation's Corporate Contract.

(ee) "Principal" means an eligible business which has received a commitment for a Bond. In order to be an eligible business, the business must be either:

(1) a "Small Business" as defined in part 121 of chapter 1 of title 13 of the Code of Federal Regulations, as amended; or

(2) a business located within an enterprise zone, as defined in subdivision (d) of section 7072 of the Government Code.

(ff) "Proposal" means a written application to become a Corporation submitted to the Agency, and containing the information set forth in section 5061.

(gg) "Proposer" means the persons or entity submitting a Proposal to the Agency.

(hh) "Remedial Action Plan" means a written set of specifications, with corresponding dates, time frame, designed to correct the problems which resulted in the Suspension Notice or Withdrawal Notice to a Corporation.

(ii) "Revolver Loan" means a Line of Credit Loan which converts to a Term Loan after one year.

(jj) "Surety" means an insurance company licensed by the California Department of Insurance, and authorized to conduct business in California.

(kk) "Suspension" means that a Corporation is no longer registered with the Secretary of State as a small business development corporation and shall not enjoy any of the benefits of a small business development corporation.

(*ll*) "Temporary Withdrawal" means a limited term suspension of a Corporation's powers to execute Guarantees as long as the Temporary Withdrawal is in effect.

(mm) "Term Loan" means a Loan with regularly scheduled reductions in principal balance.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002, 14010, 14028, 14036, 14037.6, 14038, 14041, 14071 and 14071.5, Corporations Code.

HISTORY

1. New chapter 7 (sections 5000 through 5012, 5020 through 5022, 50230, 5040 through 5046, 5060, 5061, 5070 through 5076) filed 5–27–69 as an emergency; effective upon filing (Register 69, No. 22).
2. Certificate of Compliance–Sec. 11422.1, Gov. Code, and amendment effective thirtieth day after filing, filed 9–23–69 (Register 69, No. 39).
3. Amendment to NOTE and section filed 6–3–77; effective thirtieth day thereafter (Register 77, No. 23).
4. Repealer of chapter 7 (sections 5000–5110) and new chapter 7 (sections 5000–5076) filed 5–30–80; effective thirtieth day thereafter (Register 80, No. 22). For prior history see Registers 69, No. 39; 70, No. 46; 71, No. 10; 72, No. 33; 77, No. 13; 77, No. 23; 77, No. 41; 78, No. 17; 79, No. 50 and 80, No. 15.
5. Editorial correction filed 5–19–82 (Register 82, No. 21).
6. Repealer and new section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
7. Amendment of chapter heading and new subsections (c)–(c)(4), (i)–(i)(2), (k), (o) and (w), subsection relettering, and amendment of NOTE filed 11–4–93 as an emergency; operative 11–4–93 (Register 93, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–4–94 or emergency language will be repealed by operation of law on the following day.
8. Amendment of section and NOTE filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 11–4–93 order transmitted to OAL 3–3–94 and filed 3–15–94 (Register 94, No. 11).
10. Reinstatement of section as it existed prior to emergency amendment filed 2–16–95 by operation of Government Code section 11346.1(f) (Register 95, No. 7).
11. Amendment filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).
13. Amendment of section and NOTE filed 1–19–99 as an emergency; operative 1–19–99 (Register 99, No. 4). A Certificate of Compliance must be transmitted to OAL by 7–19–99 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 1–19–99 order, including further amendment of subsections (a) and (k), repealer of subsection (cc) and subsection relettering, transmitted to OAL 6–3–99 and filed 7–9–99 (Register 99, No. 28).
15. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
16. Editorial correction of HISTORY 15 (Register 2005, No. 27).
17. Certificate of Compliance as to 12–27–2004 order, including amendment of chapter heading and NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
18. New subsections (u) and (bb) and subsection relettering filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5001. Guarantee Procedures.

The potential Borrower applying for a Guarantee shall provide a completed Application to the Corporation for review and processing in accordance with the following procedures:

(a) No Guarantee shall be executed by a Corporation until the proposed Guarantee has been reviewed by the Corporation's loan committee and approved by its Board of Directors, unless the Corporation's Board of Directors has delegated the authority to approve a proposed Guarantee to the Corporation's loan committee. No Guarantee shall be approved or executed by a Corporation if the Lender is the same entity as the Corporation issuing the Guarantee.

(b) Upon completion of the review and approval by the Corporation's loan committee and/or Board of Directors, the Corporation shall issue a commitment to Guarantee and an executed Guarantee to the Lender.

(c) In the event that a Guarantee is issued to a Lender without first complying with the requirements of subsection (a), and the Lender relies upon the Guarantee in making the Loan, the failure by the Corporation to so comply shall not constitute a defense on the part of either the Agency or the Corporation to paying a Demand for payment made pursuant to section 5003.

(d) In any case where funds are disbursed to a Lender pursuant to a Demand and the Corporation has failed to comply with subsection (a), the Agency shall immediately exercise all available legal remedies to recover from the Corporation the funds disbursed pursuant to the Demand.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14055, 14060, 14064 and 14071, Corporations Code.

HISTORY

1. Order of Repeal filed 6–3–85 by OAL pursuant to Government Code Section 11349.7; effective thirtieth day thereafter (Register 85, No. 26).
2. Repealer and new section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
3. Amendment of subsections (a)–(c) filed 6–9–97 as an emergency; operative 6–9–97 (Register 97, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–7–97 or emergency language will be repealed by operation of law on the following day.
4. Reinstatement of subsections (a)–(c) as they existed prior to 6–9–97 emergency amendment by operation of Government Code section 11346.1(f) (Register 98, No. 30)
5. Amendment of subsections (a)–(c) and NOTE filed 7–24–98; operative 7–24–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 30).
6. Amendment of subsections (c)–(d) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of HISTORY 6 (Register 2005, No. 27).
8. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5002. Guarantee Terms.

(a) Following adoption of a resolution by its board of directors, a Corporation shall be authorized to issue a commitment letter specifying the conditions under which it will issue a Guarantee to a specified Borrower. A commitment letter for a Line of Credit Loan shall include a section describing the three (3) alternatives which exist at the maturity of the Loan. The Lender, not less than thirty (30) calendar days prior to the expiration of the Guarantee, shall notify the Corporation whether the Loan is current, whether any problems currently exist with the Loan, and the expiration date. Lender and Corporation shall agree to one of the following three (3) alternatives:

(1) Renew the Guarantee, but as a Term Loan, not a Line of Credit Loan;

(2) Renew the Guarantee as a Line of Credit Loan; or

(3) Do not renew the Guarantee.

(b) The terms and conditions of a Guarantee shall be consistent with the resolution of the Corporation approving the Guarantee and shall include all of the following:

[The next page is 833.]

(1) Provision that the Corporation promises to pay up to ninety percent (90%) of the principal and interest on a Line of Credit Loan and Term Loan, and up to one–hundred percent (100%) of the principal and interest on a Micro Loan, or other Loan approved by the Director, subject only to the following restrictions:

(A) The Lender has complied with all material conditions contained in the Guarantee, including perfecting Collateral; and

(B) The Lender has not engaged, and will not engage, in fraudulent or grossly negligent practices in connection with the Borrower, Guarantee, the Loan or the Loan Agreement.

(2) The duration of a Guarantee on a Term Loan shall not exceed seven (7) years.

(3) The duration of a Guarantee on a Line of Credit Loan shall not exceed one (1) year, except for a Line of Credit Loan to a Farm Enterprise, where the duration of a Guarantee shall not exceed two (2) years.

(4) The Corporation shall be authorized to charge the following Loan Guarantee fees:

(A) For a loan guarantee in the amount of $150,000 or less, a loan guarantee fee not to exceed 2 percent of the principal amount guaranteed.

(B) For a loan guarantee in an amount greater than $150,000, a loan guarantee fee not to exceed 3 percent of the principal amount guaranteed.

(C) For a loan guarantee with a term greater than one year, a loan guarantee servicing fee not to exceed .5% of the principal amount guaranteed. The servicing fee shall be authorized to commence on the first anniversary of the effective date of the loan guarantee, and to continue annually until the guarantee is released.

(5) A statement that the Lender shall send to the Corporation executing the Guarantee, a copy of all Delinquency notices mailed to the Borrower.

(6) A description of the procedures and the responsibilities of the Lender and Corporation subsequent to Default.

(7) Section 5003 Demand procedures.

(8) Agreement to abide by binding arbitration by the American Arbitration Association in the event that either the Corporation or the Agency denies the requested Demand pursuant to section 5003(d)(2) or (e)(2), or the amount paid to the Lender is less than the amount contained in the Demand Letter.

(9) Acknowledgment by the Lender that in the event of a Demand, the Lender will allow a representative of the California Department of Financial Institutions, or other auditor selected by the Corporation, to examine the Lender's Loan files.

(10) A designation as to whether the Guarantee is a Collection Guarantee or Loan Guarantee.

(11) A statement that the maximum amount of interest to be paid is ninety (90) calendar days at guaranteed percentage. The ninety (90) calendar day limit can only be exceeded with the written approval of the Corporation.

(12) The maximum guarantee amount from any single trust fund account for any business is $500,000. The maximum guarantee amount from a combination of trust fund accounts for any business is $1,000,000.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14070, 14071 and 14072, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Amendment filed 4–12–88 as an emergency; operative 4–12–88 (Register 88, No. 18). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 10–11–88.
4. Amendment filed 9–19–88 as an emergency; operative 9–19–88 (Register 88, No. 39). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 3–20–89 and Section 5002 will be reprinted as it existed prior to 4–12–88.
5. Certificate of Compliance as to 9–19–88 order including amendment of subsection (g) filed 2–8–89 (Register 89, No. 8).
6. Repealer and new section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
7. New subsection (b)(12) filed 2–22–94; operative 2–22–94 (Register 94, No. 8).
8. Amendment of subsections (b)(1) and (b)(11) filed 6–9–97 as an emergency; operative 6–9–97 (Register 97, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–7–97 or emergency language will be repealed by operation of law on the following day.
9. Reinstatement of subsections (b)(1) and (b)(11) as they existed prior to 6–9–97 emergency amendment by operation of Government Code section 11346.1(f) (Register 98, No. 30)
10. Amendment of subsections (a), (b)(1), (b)(2)–(4), (b)(9) and (b)(11) and amendment of NOTE filed 7–24–98; operative 7–24–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 30).
11. Amendment of subsection (b)(12) filed 2–11–2002; operative 3–13–2002 (Register 2002, No. 7).
12. Amendment of subsection (b)(4), new subsections (b)(4)(A)–(C) and amendment of NOTE filed 11–14–2002 as an emergency; operative 11–14–2002 (Register 2002, No. 46). Pursuant to Corporations Code section 14024 a Certificate of Compliance must be transmitted to OAL by 5–13–2003 or emergency language will be repealed by operation of law on the following day.
13. Certificate of Compliance as to 11–14–2002 order transmitted to OAL 3–5–2003 and filed 4–17–2003 (Register 2003, No. 16).
14. Amendment of subsection (b)(12) filed 7–29–2003 as an emergency; operative 7–29–2003 (Register 2003, No. 31). Pursuant to Corporations Code section 14024 a Certificate of Compliance must be transmitted to OAL by 1–26–2004 or emergency language will be repealed by operation of law on the following day.
15. Editorial correction of HISTORY 14 (Register 2003, No. 49).
16. Reinstatement of subsection (b)(12) as it existed prior to 7–29–2003 amendment by operation of Government Code section 11346.1(f) (Register 2004, No. 32).
17. Amendment of subsections (b)(8) and (b)(12) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
18. Editorial correction of HISTORY 17 (Register 2005, No. 27).
19. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5003. Demand Procedures.

(a) The Lender shall be authorized to make a Demand upon the Corporation executing the Guarantee for repayment of the unpaid Loan principal and interest pursuant to the terms of the Guarantee, upon compliance with the following:

(1) Providing proof to the Corporation that the Borrower is in Default and Lender has delivered to both the Borrower and the Corporation a minimum of two letters subsequent to the Delinquency, at least thirty (30) days apart, explaining the consequences for failure to remedy the Delinquency. This requirement shall not apply if Borrower is in bankruptcy.

(2) If the Guarantee is a Collection Guarantee, providing proof that the Borrower has complied with the liquidation requirements of section 5004.

(b) The Lender shall deliver to the Corporation executing the Guarantee a Demand Letter requesting immediate payment of the guaranteed portion of Loan interest and principal, and documenting compliance with subsection (a).

(c) Within five (5) days of receipt of the Demand letter, the Corporation shall contract with the California Department of Financial Institutions or an independent auditor to conduct an investigation to determine whether the Lender has complied with the terms of the Guarantee, and to issue a report to both the Corporation and the Agency. The investigation shall address each of the following issues:

(1) Whether the Loan agreement between the Borrower and Lender is consistent with the terms and conditions in the Guarantee?

(2) Has all Collateral for the Loan and Guarantee been perfected and maintained? Is all Collateral available for assignment to the Corporation in the event that payment is made upon the Demand: Is any Collateral not available as a result of Lender's negligence, breach of contract, foreclosure or other cause? If yes, describe.

(3) If the Guarantee is a Collection Guarantee, has the Lender complied with the liquidation procedures of section 5004?

(4) Calculation on the outstanding principal and interest owed.

(5) Whether the Lender complied with the procedures for making a Demand under section 5003(b).

(6) In a section entitled "Loan Information" the report shall include the following information obtained solely from a review of Lender files: a description of the Borrower's business, a description of the Collateral for the Loan, and a discussion as to whether the Lender files contain any ref-

erence to matters material to Borrower's compliance with any environmental laws or regulations. The description of Collateral shall identify all real property Collateral as one or more of the following: industrial, commercial, agricultural, single family residence, multi-unit residential, vacant lot, unknown.

(7) A Loan history.

(d) Within five (5) days of receiving the California Department of Financial Institutions or auditor's report, the Corporation shall do one of the following:

(1) Deliver to the Agency a request for payment on the Demand, along with: a copy of the report described in subsection (c), the Demand, and a calculation of the amount owed pursuant to the Guarantee; or

(2) Deliver to the Lender, with a copy simultaneously delivered to the Agency, a refusal to make payment pursuant to the Demand, and detailing the reasons for refusal.

(e) Within ten (10) calendar days from the date the Agency receives the request for payment, the Agency shall do one of the following and simultaneously inform the Lender of such action:

(1) Deliver or cause to be delivered to the Corporation a check in an amount not to exceed the amount contained in the Demand Letter, made payable to the Lender; or

(2) Deliver or cause to be delivered a denial of the request for payment to the Corporation based upon fraud or gross negligence on the part of the Lender known to the Agency.

(3) Deliver or cause to be delivered to the Corporation a statement that the investigation was incomplete, and requiring the Corporation to complete the investigation and resubmit the request for payment to the Agency within five (5) calendar days from the date the statement is received by the Corporation.

(f) The amount paid to the Lender pursuant to a Demand Letter shall be less than the amount contained in the Demand Letter only under the following circumstances:

(1) The Demand contains an incorrect calculation of the amount owing;

(2) The amount owing on the Loan has been reduced by subsequent payments from the Borrower to the Lender; or

(3) The Lender has engaged in fraudulent activities pertaining to the Loan.

(g) Within one working day of receiving the check from the Agency, the Corporation shall contact the Lender and arrange to deliver the check to the Lender. The Corporation shall deliver the check and simultaneously collect an assignment by the Lender of the Lender's interest in the Loan. The assignment shall include the Loan Note and all Collateral, except as provided in section 5004.

(h) The Guarantee shall include a provision for binding arbitration in the event that either the Corporation or Agency denies the requested Demand pursuant to subsections (d)(2) or (e)(2), or the amount paid to the Lender is less than the amount contained in the Demand Letter.

(i) Demand must be made upon the Corporation no later than noon on the thirty-first calendar day following the date on which the Guarantee terminates; provided, however, that if the thirty-first day is not a day upon which the Corporation is open for business, the last day for making a Demand shall occur on the next succeeding day upon which the Corporation is open for business.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14064, Corporations Code.

HISTORY

1. Repealer and new section filed 6-24-91; operative 7-24-91 (Register 91, No. 42).
2. Amendment of subsections (c) and (d) and amendment of NOTE filed 7-24-98; operative 7-24-98 pursuant to Government Code section 11343.4(d) (Register 98, No. 30).
3. Amendment filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2005, No. 27).
5. Certificate of Compliance as to 12-27-2004 order, including amendment of subsection (c)(5) and NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5004. Collection Requirements for Collection Guarantees.

(a) A Lender shall not be authorized to file a Demand for a Collection Guarantee unless it has complied with this section. The requirements contained in this section are in addition to the requirements contained in section 5003.

(b) The Lender must liquidate all Collateral, but shall not be required to file a lawsuit against any Borrower or guarantor. "Liquidate" as used in this paragraph means that the Lender has exhausted all Collateral by one of the following methods:

(1) converted the Collateral into cash;

(2) demonstrated, to the satisfaction of the Corporation that the Collateral is without sufficient value to convert to cash; or

(3) demonstrated that the Borrower has filed for bankruptcy.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14064, Corporations Code.

HISTORY

1. Editorial correction filed 2-16-83 (Register 83, No. 8).
2. Repealer and new section filed 6-24-91; operative 7-24-91 (Register 91, No. 42).

§ 5005. Micro Loan Program.

No Corporation shall be authorized to issue Micro Loan Guarantees unless approved by the Director. Approval shall be granted to any Corporation which can demonstrate that it has a marketing plan for the program.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14025(a) and 14064, Corporations Code.

HISTORY

1. Repealer and new section filed 6-24-91; operative 7-24-91 (Register 91, No. 42).
2. Amendment filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12-27-2004 order, including amendment of NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5006. Agency Review of Environmental Liability.

Within thirty (30) days of receiving the report prepared by the Department of Financial Institutions, pursuant to section 5003(c), the Agency shall mail to the Corporation a statement ("Environmental Instructions") specifying any specific steps which the Corporation must take in obtaining an assignment of the note and Collateral pursuant to section 5003(g), or in pursuing its legal remedies against the Borrower subsequent to assignment.

The purpose of the Environmental Instructions is to identify possible environmental liability which might accrue to the Corporation when it is assigned the Lender's rights, and instruct the Corporation on actions which it shall take, or refrain from taking, to limit the Corporation's trust fund account's exposure to environmental liability.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14064, Corporations Code.

HISTORY

1. Repealer and new section filed 6-24-91; operative 7-24-91 (Register 91, No. 42).
2. Amendment of section heading and section filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12-27-2004 order, including amendment of NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

Article 2.2. Corporation Qualifications for Bond Guarantee Authority

§ 5007. Corporation Qualifications for Bond Guarantee Authority.

A Corporation shall be authorized to issue ILOCs, Bond Guarantees and Bond Lines only upon approval by the Director. The Director shall be authorized to limit the amount of state funds which a Corporation is authorized to use for ILOCs, Bond Guarantees and Bond Lines. Approval shall be granted upon compliance with both of the following:

(a) The Corporation has established a Bond loan committee with at least one member who has experience in the surety bond industry and a majority of the members have experience in the construction or surety bond industries.

(b) The Corporation presents a written plan to the Director which coherently and logically describes how the Bond program will be managed, staffed and marketed, and describes the anticipated dollar volume of Bond Guarantees, Bond Lines and ILOCs.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002, 14055, 14060, 14071 and 14071.5, Corporations Code.

HISTORY

1. New article 2.2 and section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New article 2.2 and section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).
5. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

Article 2.3. Bond Guarantees

§ 5008. Bond Guarantee Procedures.

(a) A Principal shall be authorized to apply to a Corporation for either a Bond Guarantee, or a Bond Line.

(b) A Principal applying for a Bond Guarantee or a Bond Line shall provide a complete Application to the Corporation for review and processing in accordance with the following procedures:

(1) The proposed Guarantee has been reviewed by the Corporation's Bond loan committee and approved by its board of directors.

(2) Upon compliance with subsection (b)(1), the Corporation shall issue a commitment to provide a Bond Guarantee or Bond Line and an executed Bond Guarantee or Bond Line to the Surety.

(3) In the event that a Guarantee is issued to a Surety without first complying with the requirements of subsections (b)(1) and/or (c), and the Surety relies upon the Guarantee in issuing the Bond, the failure by the Corporation to so comply shall not constitute a defense on the part of either the Agency or the Corporation to paying a Claim.

(4) In any case where funds are disbursed to a Surety pursuant to a Claim and the Corporation has failed to comply with subsections (b)(1) and/or (c), the Agency shall immediately exercise all available legal remedies to recover from the Corporation the funds disbursed pursuant to the Claim.

(c) Any change to a Bond Guarantee or Bond Line pursuant to section 5009(e)(5) must be approved by the Corporation board of directors if the change amends the terms contained in the resolution by the Corporation board of directors approving the Guarantee.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002, 14055, 14059, 14060, 14064, 14071 and 14071.5, Corporations Code.

HISTORY

1. New article 2.3 and section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New article 2.3 and section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).
5. Amendment of subsections (b)(3)–(4) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5009. Bond Guarantee and Bond Line Terms.

The terms and conditions of a Bond Guarantee or Bond Line shall be consistent with the resolution of the Corporation approving the Bond Guarantee or Bond Line and shall include all of the following:

(a) Provision that the Corporation promises to pay Losses up to ninety percent (90%) of the Bond, not to exceed five hundred thousand dollars ($500,000), subject only to the restriction that the Surety has not engaged in gross negligence, misrepresentation, fraud, or material breach of the terms of the Guarantee in writing, issuing, or servicing the Bond.

(b) Guarantee shall expire two hundred and ten days (210) following final payment by the party requiring the Bond (Obligee) of all amounts owed to Principal pursuant to the contract bonded, so long as no notice of claims has been received by Surety and is pending as of that expiration date. In the event that a notice of claim is pending as of that expiration date, the Guarantee shall remain in effect until resolution of that claim.

(c) A Corporation Bond Guarantee fee not to exceed two percent of the Guarantee amount. In the case of a Bond Line, the fee shall be charged for each Guarantee.

(d) The terms and conditions of the Bond subject to a Guarantee which shall be in accord with those generally established and accepted by the Surety for the type of contract for which the Bond is required.

(e) A statement that:

(1) Surety would not provide the Bond without the Guarantee.

(2) Consistent with Surety's underwriting and claims handling procedures, Surety shall take all reasonable action necessary to minimize risk of Loss, including but not limited to the taking of Collateral and obtaining personal guarantees, and Surety will pursue all possible sources of recovery.

(3) If any suit is filed against Surety upon the Bond, Surety shall immediately inform Corporation of receipt of notice thereof and shall take charge of all suits or claims arising under the Bond and compromise, settle or defend such suit or claim. Surety shall take all steps necessary to mitigate the Loss resulting from Principal's default. Surety shall not join Corporation in any lawsuit to which Surety is a party unless Corporation has denied a Claim.

(4) Liability of the Corporation under the Guarantee shall be reduced if the Guarantee requires Surety to take Collateral, and Surety fails to obtain and perfect the Collateral. In the event that the Surety fails to take or perfect Collateral required by the terms of the Guarantee, the liability of the Corporation pursuant to the Guarantee shall be reduced by the Guarantee percentage of the amount which could reasonably have been recovered by liquidating the Collateral.

(5) The terms of the Guarantee shall not be waived, changed or altered unless both Corporation and Surety's authorized representative have signed and dated assent thereto.

(6) Corporation shall have access to and the right to audit and inspect any and all documents maintained by the Surety related to the Bond. The audit shall be conducted in a reasonable manner during business hours or as otherwise agreed upon between Corporation and Surety.

(7) The Guarantee is made exclusively for the benefit of Corporation and Surety and does not confer any rights or benefits to any other party. In the event of the Surety's insolvency, Corporation shall not be liable to the receiver or trustee of the insolvent estate except for any Loss.

(f) In the case of a Bond Line, the document shall also specify the following:

(1) The Bond Line shall only apply to Bonds issued by the identified Surety, to the specified Principal.

(2) No Bond shall be guaranteed under the Bond Line if that Bond is dated either before the effective date of the Bond Line, or later than 365 days following the effective date of the Bond Line.

(3) The Bond Line shall specify the guarantee percentage for the Guarantees issued under the Bond Line.

(4) The Bond Line shall specify the maximum Guarantee authority, which shall not exceed $500,000. The combined Guarantee liability of all Bonds outstanding for a specific Principal shall not exceed $1,000,000, pursuant to the provisions in subsection 5002(b)(12). A Principal with a Bond Line shall obtain a Guarantee under the Line by sending a copy of the Bond to the Corporation, which shall sign and attach to the Bond a statement that the Bond is guaranteed by the Corporation pursuant to the terms of the Bond Line. This statement shall be signed so long as the Principal and Bond comply with the terms of the Bond Line.

(5) It shall be the responsibility of the Surety to notify the Corporation when a Guarantee under a Bond Line has expired.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002, 14055, 14070, 14071, 14072 and 14071.5, Corporations Code.

HISTORY

1. New section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).
5. Amendment of subsections (a), (b) and (f)(4) and amendment of NOTE filed 7–29–2003 as an emergency; operative 7–29–2003 (Register 2003, No. 31). Pursuant to Corporations Code section 14024 a Certificate of Compliance must be transmitted to OAL by 1–26–2004 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2003, No. 49).
7. Reinstatement of subsections (a), (b) and (f)(4) and reinstatement of NOTE as they existed prior to 7–29–2003 amendment by operation of Government Code section 11346.1(f) (Register 2004, No. 32).
8. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
9. Editorial correction of HISTORY 8 (Register 2005, No. 27).
10. Certificate of Compliance as to 12–27–2004 order, including amendment of subsection (b) and NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5010. Bond Guarantee Claim Procedures.

(a) Surety shall be entitled to reimbursement for the percentage of its Loss covered by the Guarantee, adjusted pro rata for payments received by Surety from any other source, excluding reinsurance, upon compliance with the following:

(1) Notify Corporation in writing within forty–five (45) days after the end of each calendar quarter after the Surety has established a claim reserve on the Claim.

(2) Ninety (90) days after notice to Corporation that the claim reserve has been established and every thirty (30) days thereafter, unless mutually agreed upon otherwise, Surety shall provide Corporation with the current status of the Claim, including salvage prospects, and proof of payment by Surety of the Claim. Claim reporting can be on Corporation's Current Status Report form or Surety's equivalent.

(3) Surety shall invoice the Corporation quarterly for any Loss, except that Surety shall be authorized to invoice the Corporation monthly for a Loss in excess of five thousand dollars ($5,000). Corporation shall submit for payment to the Agency within twenty (20) days of receipt, any invoice received from a Surety for a Loss that complies with the requirements of this article.

(b) After payment has been made by Corporation, if any net amount is recovered by Surety from any other source, excluding reinsurance, Corporation is entitled to the Guarantee percentage of said net amount upon actual receipt by the Surety. Subrogation efforts shall be discontinued by Surety only after providing Corporation with written documentation substantiating insolvency or the inability to pay on the part of Principal or others who agreed to indemnify the Surety, unless otherwise mutually agreed by the Surety and Corporation. In the event of discontinuation of subrogation efforts by Surety, the Surety will assign all of its right, title and interest to recovery to the Corporation.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002, 14055, 14071 and 14071.5, Corporations Code.

HISTORY

1. New section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–16–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).
5. Amendment of subsections (a)(1)–(2) and amendment of NOTE filed 7–29–2003 as an emergency; operative 7–29–2003 (Register 2003, No. 31). Pursuant to Corporations Code section 14024 a Certificate of Compliance must be transmitted to OAL by 1–26–2004 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2003, No. 49).
7. Reinstatement of subsections (a)(1)–(2) and reinstatement of NOTE as they existed prior to 7–29–2003 amendment by operation of Government Code section 11346.1(f) (Register 2004, No. 32).
8. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
9. Editorial correction of HISTORY 8 (Register 2005, No. 27).
10. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

Article 2.5. ILOC as Bond Collateral

§ 5013. ILOC Procedures.

A Principal shall be authorized to apply to a Corporation for an ILOC. A Principal applying for an ILOC shall provide a completed Application to the Corporation for review and processing in accordance with the following procedures:

(a) The proposed ILOC has been reviewed by the Corporation's Bond loan committee and approved by its board of directors.

(b) Upon compliance with subsection (a), the Corporation shall issue an ILOC commitment and an executed ILOC to the Surety.

(c) In the event that an ILOC is issued to a Surety without first complying with the requirements of subsection (a) and/or (e), and the Surety relies upon the ILOC in issuing the Bond, the failure by the Corporation to so comply shall not constitute a defense on the part of either the Agency or the Corporation to paying a Demand.

(d) In any case where funds are disbursed to a Surety pursuant to a Demand and the Corporation has failed to comply with subsections (a) and/

or (e), the Agency shall immediately exercise all available legal remedies to recover from the Corporation the funds disbursed pursuant to the Demand.

(e) Any change to a Bond Guarantee or Bond Line pursuant to section 5014(f)(3) must be approved by the Corporation board of directors if the change amends the terms contained in the resolution by the Corporation board of directors approving the Guarantee.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002, 14055, 14059, 14060, 14064, 14071 and 14071.5, Corporations Code.

HISTORY

1. New article 2.5 and section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New article 2.5 and section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).
5. Amendment of subsections (c)–(d) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of subsection (e) and NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5014. ILOC Terms.

The terms and conditions of an ILOC shall be consistent with the resolution of the Corporation approving the ILOC and shall include all of the following:

(a) Provision that the Corporation promises to pay a specified amount to Surety upon Surety establishing a claim reserve.

(b) The maximum amount of the ILOC shall be 15% of the contract amount, not to exceed $350,000.

(c) Where the Bond is for a public works project, a statement that the ILOC shall expire one hundred and twenty days following receipt by Surety of a statement from the party requiring the Bond ("Obligee") that the work has been completed and fully accepted and that Obligee has made payment of all amounts owed the Principal pursuant to the Bond. The ILOC shall expire only if no notice of Claim is pending with the Surety. If the Bond is for other than a public works project, then the Corporation and Surety shall include in the ILOC what events and timing trigger expiration of the Guarantee.

(d) The Corporation fee not to exceed two percent of the ILOC amount.

(e) The terms and conditions of the Bond collateralized by the ILOC shall be in accord with those generally established and accepted by the Surety for the type of contract for which the Bond is required.

(f) A statement that:

(1) Surety would not provide the Bond without the ILOC.

(2) Surety shall not join Corporation in any lawsuit to which Surety is a party unless Corporation has denied a Demand.

(3) The terms of the ILOC shall not be waived, changed or altered unless both Corporation and Surety's authorized representative have signed and dated assent thereto.

(4) Corporation shall have access to and the right to audit and inspect any and all documents related to the Bond. The audit shall be conducted in a reasonable manner during business hours or as otherwise agreed upon between Corporation and Surety.

(5) The ILOC is made exclusively for the benefit of Corporation and Surety and does not confer any rights or benefits to any other party. In the event of the Surety's insolvency, Corporation shall not be liable to the receiver or trustee of the insolvent estate except for any Loss.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14002, 14055, 14071 and 14071.5, Corporations Code.

HISTORY

1. New section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).

§ 5015. ILOC Demand Procedures.

(a) Upon the establishment of a claim reserve connected to the Bond, Surety shall be authorized to make Demand upon the Corporation for an amount equal to the Loss incurred, and reasonably expected to be incurred within the next sixty calendar sixty (60) days by the Surety.

(b) Demand shall be made in writing, and shall include a statement that a Claim reserve has been established, shall explain why the Claim reserve has been established, and shall specify the amount of the Demand.

(c) Corporation shall mail to Surety, not later than ten (10) calendar days from receipt of Demand, either the amount included in the Demand or an explanation of why the amount requested in the Demand will not be paid by the Corporation. The only reasons for refusing to pay the amount included in the Demand are:

(1) No Claim reserve has been established for the Bond covered by the ILOC.

(2) The amount requested in the Demand lacks reasonable supporting documentation.

(d) After payment has been made by a Corporation, if any net amount is recovered by Surety from any other source, excluding reinsurance, Corporation is entitled, upon actual receipt by the Surety, to the percentage of said net amount which equals the ILOC funds paid as a percentage of Loss paid by the Corporation. Subrogation efforts shall be discontinued by Surety only after providing Corporation with written documentation substantiating insolvency or the inability to pay on the part of Principal or others who agreed to indemnify the Surety, unless otherwise mutually agreed by the Surety and Corporation. In the event of discontinuation of subrogation efforts by Surety, the Surety will assign all of its right, title and interest to recovery to the Corporation.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14002, 14055, 14071 and 14071.5, Corporations Code.

HISTORY

1. New section filed 2–15–94 as an emergency; operative 2–15–94 (Register 94, No. 7). A Certificate of Compliance must be transmitted to OAL by 6–15–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–17–95 as an emergency; operative 4–17–95 (Register 95, No. 16). A Certificate of Compliance must be transmitted to OAL by 8–15–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4–17–95 order transmitted to OAL 6–12–95 and filed 7–25–95 (Register 95, No. 30).

Article 3. Secondary Market for Guaranteed Portion of Loans

§ 5020. Sale of Guaranteed Portion of Loan.

(a) The Lender shall have the option of retaining all of the Loan. If the Lender desires to assign or participate all or a portion of the guaranteed portion of the Loan at or subsequent to Loan closing, the Loan must not be in Default. The Lender is not permitted to assign or participate any amount of the guaranteed or unguaranteed portions of the Loan to any of the following:

(1) the Borrower, or member of the immediate family of the Borrower, their officers, directors, stockholders, other owners or any parent, subsidiary or affiliate;

(2) a Corporation or any employee or a member of the Board of Directors of a Corporation or

(3) any employee of the Agency.

(b) The Lender may assign all or part of the guaranteed portion of the Loan to one or more Holders, except that the Lender is required to retain a minimum of ten percent (10%) of the Loan amount, and the Lender shall retain the responsibility for servicing the Loan.

(c) The Lender shall notify the Corporation of the assignment no later than forty–five (45) days following the assignment. No later than fifteen (15) days following the notification provided by the Lender, the Corporation shall register the assignment by completing and submitting the Assignment Registration Form (Form CTCA–047, new, 1998) to the Agency. No later than thirty (30) days following the submission of the Assignment Registration Form, the Agency shall notify the Lender and Holder of the registration.

(d) The Assignment Registration Form shall consist of the items listed below:

(1) The date of assignment or participation.

(2) The Loan number.

(3) A description of the Loan including: whether the Loan is a credit agreement or a promissory note, the date the Loan was executed, and the name of the Borrower.

(4) The outstanding balance of the Loan.

(5) The percent of Guarantee assigned to the Holder.

(6) A certification that the Loan is not in Default and not a pending Default.

(7) A certification that Holder complies with the requirements described in subsections (a)(1) through (a)(3).

(8) The Holder's contact person, mailing address, telephone number, and if available facsimile number and e–mail address.

(9) The Lender's contact person, mailing address, telephone number, and if available facsimile number and e–mail address.

(10) The titles and dated signatures of the Lender, the Holder, and the Corporation.

(e) When a guaranteed portion of a Loan is sold by the Lender to a Holder, the Holder shall succeed to all rights of Lender under the Guarantee in proportion to the amount of the Loan purchased. The Lender shall remain bound to all the obligations under the Guarantee.

(f) The Lender shall be responsible for servicing the entire Loan, and shall remain the secured party of record. The entire Loan shall be secured by the same security with equal lien priority for the guaranteed and unguaranteed portions of the Loan.

(g) The Guarantee and right to issue a Demand will be directly enforceable by Holder notwithstanding any fraud or misrepresentation by Lender or any unenforceability of the Guarantee by Lender, unless Holder has actual knowledge of said fraud, misrepresentation or unenforceability of the Guarantee prior to purchase. Notwithstanding the provisions of section 5003(a), the Holder shall be authorized to make Demand upon the Lender, with a copy sent to the Corporation, when any payment owed pursuant to the Loan is sixty (60) days in arrears, and the Holder shall be under no obligation to delay Demand pending liquidation of Collateral if the Loan is a Collection Guarantee. If Holder has not received a response with thirty (30) days agreeing to purchase the guaranteed portion of the Loan, the Holder shall be authorized to send a Demand to the Corporation. It shall be the responsibility of the Corporation to verify the Demand figures provided by the Holder with the Lender. In any dispute the Lender Demand figures shall be used. The Holder shall be entitled to receive interest on the unpaid portion of the guaranteed portion of the Loan until the Demand payoff is mailed to the Holder.

(h) Nothing contained herein shall constitute any waiver by the Agency or the Corporation of any rights they possess against the Lender, and the Lender agrees that it will be liable and will promptly reimburse the trust fund for any payment made by the Agency to Holder which, if such Lender had held the Guaranteed portion of the Loan, the Agency would not be required to make.

NOTE: Authority cited: Sections 14024 and 14070(a), Corporations Code. Reference: Sections 14070 and 14071, Corporations Code.

HISTORY

1. Repealer and new section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
2. Amendment of section and NOTE filed 1–19–99 as an emergency; operative 1–19–99 (Register 99, No. 4). A Certificate of Compliance must be transmitted to OAL by 7–19–99 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 1–19–99 order, including repealer and new subsection (c) and correction of subsection lettering and numbering, transmitted to OAL 6–3–99 and filed 7–9–99 (Register 99, No. 28).
4. Amendment of subsections (a)(3), (c) and (h) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5021. Contents of Application.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14010(k), 14024, 14032, 14035 and 14125(a) and (c), Corporations Code.

HISTORY

1. Editorial correction filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5022. Winding–Up and Dissolution.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14034 and 14121, Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5023. Lender Eligibility.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Sections 14024, 14125 and 14131(c), Corporations Code.

HISTORY

1. New section filed 4–12–88 as an emergency; operative 4–12–88 (Register 88, No. 18). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 10–11–88.
2. New section with amendment refiled 9–19–88 as an emergency; operative 9–19–88 (Register 88, No. 39). A Certificate of Compliance must be transmitted to OAL within 180 days or section 5023, as adopted and amended by emergency action, will be repealed on 3–20–89.
3. Certificate of Compliance as to 9–19–88 order including amendment filed 2–8–89 (Register 89, No. 8).
4. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5030. Application for Funds.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14024, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5035. Allocation.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14023.5(k), 14025, 14041, 14046 and 14048, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5035.1. Intercorporate Loan of Guarantee Authority.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023(a), 14023.5(k), 14025.2, 14041, 14044, 14048, 14126(a), and 14130, Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).

2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5035.2. Method of Disbursing Funds.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14044, 14045 and 14115, Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5036. Report of Fund Condition.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14023.5(k), 14044, 14045, 14046 and 14127(a), Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5036.1. Acceptable Investments of Corporate Loan Guarantee Funds.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Sections 14044, 14046, 14115 and 14131(c), Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Amendment filed 4–12–88 as an emergency; operative 4–12–88 (Register 88, No. 18). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 10–11–88.
3. Amendment filed 9–19–88 as an emergency; operative 9–19–88 (Register 88, No. 39). A Certificate of Compliance must be transmitted to OAL within 180 days or the emergency language will be repealed on 3–20–89 and Section 5036.1 will be reprinted as it existed prior to 4–12–88.
4. Certificate of Compliance as to 9–19–88 order filed 2–8–89 (Register 89, No. 8).
5. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5037. Loan Committee.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14046(a), 14066 and 14081, Corporations Code.

HISTORY

1. Editorial correction filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5038. Corporation Director's Action on Applications.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14046, 14081 and 14127, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5038.1. Corporate Report of Financial Assistance.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14023.5(d) and (k), 14024(c), 14046 and 1417(a), Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5039. Corporate Compliance to Loan Criteria.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference:Sections 14022(b), 14023.5(k), 14025, 1046(a) and 14048, Corporations Code.

HISTORY

1. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5040. Default Claim Procedures.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023.5(k), 14046(a), 14129(g) and 14131(a) and (b), Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5041. Terms of Guarantee.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023.5(k), 14046(a) and 14131(a) and (b), Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5042. Conditions of Guarantee.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023.5(k), 14046(a), 14129(g) and 14131(a) and (b), Corporations Code.

HISTORY

1. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5043. Legal Proceedings by or Against Borrowers.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023.5(k), 14046(a), 14129(g), 14131(a) and (b), Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82. No.2).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5044. Release of Guarantee.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14046(a), 14081 and 14131(a) and (b), Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 2).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5045. Procedure and Responsibilities of Involved Parties for the Sale of the Guaranteed Portion of Notes on the Secondary Market.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14090, Corporations Code.

HISTORY

1. New section filed 3–9–82;effective thirtieth day thereafter (Register 82, No. 11).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5046. Default of Notes Held by Third Party Investors.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14090, Corporations Code.

HISTORY

1. New section filed 3–9–82;effective thirtieth day thereafter (Register 82, No. 11).
2. Editorial correction of subsection (c) filed 2–16–83 (Register 83. No.8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

Article 4. Suspension of a Corporation

§ 5050. Temporary Withdrawal; Corporate Response.

(a) If the Director determines that irreparable harm may occur without Temporary Withdrawal, the Director shall notify the Corporation of its finding by personal service at the Corporation's main office ("Withdrawal Notice") and by registered mail to each member of the Board of Directors. The Temporary Withdrawal shall be in effect upon receipt of the Withdrawal Notice by the Corporation.

(b) The Withdrawal Notice shall include the following:

(1) An affidavit, executed by the Director, setting out the facts upon which the finding of irreparable harm is based, including citation to the specific provisions of the law or implementing regulations with which the Corporation has failed to comply; and

(2) A description of any documents which the Director relied upon in making the findings.

(c) The Temporary Withdrawal shall automatically terminate thirty–one (31) calendar days after it becomes effective unless:

(1) The Director has previously issued a Suspension Notice pursuant to Section 5051(b);

(2) The Director finds that the Corporation has failed to comply with the California Small Business Financial Development Corporation Law; or

(3) The Director terminates the Temporary Withdrawal.

(d) Within thirty (30) calendar days of the effective date of the Temporary Withdrawal Notice or any additional time as mutually agreed between the Director and the Corporation, the Corporation shall mail to the Director the following information ("Corporate Response").

(1) Whether the Corporation accepts the Temporary Withdrawal, or disagrees with it. If the Corporation does not accept the Temporary With-

drawal, the Corporation shall specify each fact contained within the Temporary Withdrawal Notice which it disputes;

(2) Any information which the Corporation believes mitigates or explains the facts upon which the Temporary Withdrawal is based; including the Corporation's history and past performance; and

(3) Designation of an individual, who shall be either an officer of the Corporation or legal counsel for the Corporation, who is authorized to receive any additional notice regarding the Temporary Withdrawal or Suspension of the Corporation.

(e) Not later than ten (10) calendar days after the effective date of the Temporary Withdrawal, the Corporation may request a hearing before the Board, pursuant to Section 5051(c), to contest the determination of the Director. The request for a hearing should be sent by certified mail to the Director and by registered mail to the chair of the Board, both at 980 9th Street, Suite 2450, Sacramento, California 95814.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14028, Corporations Code.

HISTORY

1. New section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
2. Amendment of section heading and section filed 6–9–97 as an emergency; operative 6–9–97 (Register 97, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–7–97 or emergency language will be repealed by operation of law on the following day.
3. Reinstatement of section heading and section as they existed prior to 6–9–97 emergency amendment by operation of Government Code section 11346.1(f) (Register 98, No. 30)
4. Amendment of section heading, section and NOTE filed 7–24–98; operative 7–24–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 30).
5. Amendment of subsection (e) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of subsection (c)(2) and NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5051. Suspension; Suspension Board Hearing Procedure; Temporary Withdrawal Board Hearing Procedure.

(a) Upon a finding that a Corporation has failed to substantially comply with one or more of the criteria described in subsections (1) through (4), the Director may suspend the Corporation or suspend the Corporation, with suspension stayed until the Director approves a Remedial Action Plan submitted by the Corporation. Suspension of a Corporation requires a finding that irreparable harm will occur unless the Corporation is suspended and a finding that the Director has considered the Corporation's history and past performance.

(1) The California Small Business Financial Development Corporation Law and implementing regulations;

(2) The plan of operation specified in Corporations Code section 14025(d);

(3) Fiscal and portfolio requirements as contained in the fiscal and portfolio audits specified in section 14027; or

(4) Milestones and scope of work as contained in the annual contract between the Corporation and the Agency.

(b) The Director shall issue a Notice of Proposed Suspension ("Suspension Notice"), which shall include the facts upon which the proposed Suspension is based. The Suspension Notice shall include a statement that the Corporation is entitled to a hearing pursuant to this section. The Suspension Notice shall be served by registered mail.

(c) Not later than ten (10) calendar days before the effective date of a Suspension, the Corporation shall mail a statement to the Director specifying whether it requests a hearing to contest the Suspension. The statement shall be mailed to the Chair of the Board and to the Director, both at 980 9th Street, Suite 2450, Sacramento, California 95814. If the statement is not mailed to the Director's Office not later than ten (10) days before the effective date of a Suspension, the Corporation shall waive all rights to a hearing. However, the Director shall be authorized, for good cause shown, to set aside the Corporation's waiver of its right to a hearing and reinstate the Corporation's full appeal rights. Provided however, that any request for reinstatement of a Corporation's full appeal rights is received by the Director within forty–five (45) calendar days of receipt of the Suspension Notice.

(d) If the Corporation mails to the Director a timely request for hearing, or waiver of hearing is set aside, the Director shall deliver to the Chair of the Board a copy of the Suspension Notice and the Corporation's response. The Corporation's response shall include a designation of a representative who can receive future Suspension and hearing notices. The response shall include the name, title, address and telephone number of the designated representative.

(e) Within thirty (30) calendar days of receiving a request for hearing, or setting aside or waiver of hearing, the Board shall determine whether it will hear the matter as a full Board, or elect a subcommittee consisting of not fewer than five (5) Board members to hear the matter. If the Board decides to elect a subcommittee, each member of the subcommittee must be acceptable to both the Director and the Corporation. If the Board elects a subcommittee, the subcommittee shall issue findings, and the full Board shall make a decision pursuant to subsection (*l*) based upon the subcommittee findings.

(f) The Board or its subcommittee shall employ an Administrative Law Judge from the Office of Administrative Hearings, Department of General Services, to conduct the hearing and to advise the Board or subcommittee on the preparation of its findings or decision. The hearing shall be conducted pursuant to the procedures contained in Government Code section 11500, *et seq.*, and the Board shall be authorized to conduct the hearing in executive session, as pursuant to Government Code section 11126.

(g)(1) Within thirty (30) days of a Corporation requesting a hearing, either the Corporation or Director shall have the right to request discovery. Discovery requests shall be limited to the following:

(A) Names, titles and addresses of witnesses at the hearing; and

(B) A request for any documents in the possession of the other party which are relevant to the determinations to be made at the hearing, and which are not privileged under any provision of law.

(2) The obligation to provide discovery, once request is properly made, shall be a continuing one. Any witnesses and documents which are not identified at least five (5) working days prior to the hearing date shall be inadmissible at the hearing, unless a finding is made on the record that the witness or document was not reasonably available and identifiable to the party presenting it prior to the hearing.

(h) Any dispute as to the discoverability of the identity of a witness or the discoverability or admissibility of a document, shall be adjudicated by the Administrative Law judge at a conference prior to the hearing, to be scheduled at the convenience of the parties. The Administrative Law judge shall preside over the conference, at which documents shall be marked, and the order of presentations shall be determined.

(i) Each party shall have the following rights at the hearing:

(1) To call and to cross–examine witnesses, and to introduce relevant exhibits and documents;

(2) To cross–examine and impeach witnesses;

(3) To introduce any relevant evidence, including hearsay, if it is the sort of evidence on which responsible parties are accustomed to rely in the conduct of serious affairs. However, no finding of the Board at the conclusion of the hearing shall be based solely on hearsay unless corroborated by direct evidence, or admissible in a civil proceeding over a hearsay objection.

(j) Members of the Board, through the Administrative Law Judge, may interrogate witnesses or call additional witnesses if the Board deems such action appropriate. In its sole discretion, the Board may allow either or both parties to present written argument at the conclusion of the hearing.

(k) At the hearing the Director or his or her designee, shall have the initial burden of presenting evidence supporting the conclusion that the Suspension is appropriate. On completing such presentation, the burden

of going forward with the evidence shall pass to the Corporation, which shall then have the burden of persuading the Board, by a preponderance of the evidence, that the Suspension is not supported by the facts. Subsequent to the Corporation's presentation, the Director or his or her designee shall have the right to rebut the Corporation's contentions.

(*l*) At the conclusion of the hearing, the Administrative Law judge, in conference with the Board, shall prepare a written decision, or, in a case where the hearing was conducted by a subcommittee, shall prepare written findings. If a subcommittee conducted the hearing, the findings shall be presented to the full Board, and the Administrative Law judge shall prepare a written decision for the Board. The decision shall be based on the evidence introduced at the hearing, and the testimony presented. The written decision shall be signed by the chair of the Board, or his or her designee. Issuance of the written decision shall constitute completion of the administrative hearing process. The decision shall include findings of fact and conclusions of law demonstrating one of the following:

(1) Suspension is appropriate, effective upon issuance of the decision;

(2) Suspension is appropriate, with Suspension stayed until the Corporation adopts a specified Remedial Action Plan and presents it to the Board, and the Board adopts a resolution repealing or implementing the Suspension;

(3) Suspension is not appropriate so long as the Corporation adopts a specified Remedial Action Plan which is approved by the Director within a period of time specified in the decision. Failure of the Corporation to comply with this subsection shall be reviewed by the Board at its next regularly scheduled meeting, and the Board shall be authorized to Suspend the Corporation at that meeting; or

(4) Suspension is not appropriate.

(m) Any decision pursuant to subsection (*l*)(1) or (2) must include a finding that irreparable harm will occur unless the Corporation is Suspended.

(n) The Board shall be assisted during the Temporary Withdrawal hearing by an attorney from the Agency, the Attorney General's Office or the Office of Administrative Hearings ("Board Attorney"). The Board Attorney shall not have been involved in the investigation, development or preparation of the findings. The Board Attorney shall rule on the admissibility of any documentary evidence, supervise the oral presentation, and otherwise assist the Board with questioning the Director or his or her designee, and any representative of the Corporation. The Board Attorney shall also advise the Board on the form of its findings and conclusions, based on the presentation at the meeting. The Board Attorney shall discharge his or her responsibility relying upon the standards contained in Chapter 5, Part 1 of Division 3, Title 2 of the Government Code (commencing with section 11500).

(o) The hearing shall not take place unless there is a quorum of the Board present. If there is no quorum for the Temporary Withdrawal hearing or at a continuance of the hearing, the hearing shall be continued for not more than seven (7) calendar days, and the Temporary Withdrawal shall remain in effect until the following hearing.

(p) At the Board meeting to review the Temporary Withdrawal, the Board shall first hear the Director or his or her designee. The Director or his or her designee shall explain the basis of the Temporary Withdrawal and submit to the Board members any documents on which the Temporary Withdrawal is based, including the affidavit attached to the original Withdrawal Notice. Copies of any documents submitted by the Director shall be provided to the Corporation. The Corporation shall have an opportunity to make a presentation, which shall consist of an oral statement, documentary evidence previously submitted to the Director pursuant to subsection 5050, written statements, or combination thereof.

(q) Within thirty (30) calendar days the Board shall issue a written decision.

(r) The decision of the Board shall be limited to one of the following:

(1) Disapprove the determination made by the Director, resulting in the termination of the Temporary Withdrawal;

(2) Disapprove the requested Temporary Withdrawal subject to the Corporation's adoption of a Remedial Action Plan detailed in the Board's decision. The termination of the Temporary Withdrawal is effective upon adoption of the Remedial Action Plan by the Corporation and the certification by the Director that the Corporation has adopted the Remedial Action Plan.

(3) Continue the Temporary Withdrawal until the Board issues its decision following the Suspension hearing. This decision by the Board requires a finding that the Corporation has failed to comply with the Law, and as part of the decision, the Board shall instruct the Director to issue a Suspension Notice, pursuant to section 5051(b) not later than thirty (30) calendar days from the date of the Temporary Withdrawal hearing. The Board decision shall further state that the Temporary Withdrawal will be automatically terminated thirty–one (31) calendar days from the date of the Temporary Withdrawal hearing unless the Director has previously issued a Suspension Notice.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14028, Corporations Code.

HISTORY

1. New section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
2. Amendment of section heading and section filed 6–9–97 as an emergency; operative 6–9–97 (Register 97, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–7–97 or emergency language will be repealed by operation of law on the following day.
3. Reinstatement of section heading and section as they existed prior to 6–9–97 emergency amendment by operation of Government Code section 11346.1(f) (Register 98, No. 30)
4. Amendment of section heading, section and NOTE filed 7–24–98; operative 7–24–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 30).
5. Amendment of subsections (a)(1), (a)(4) and (c) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

Article 5. Designation of a Corporation

§ 5060. Proposal Process.

(a) The Director is authorized to adopt a resolution of intent to establish a new Corporation. The resolution shall include the following information:

(1) The geographic service area for the new Corporation;

(2) The date when the Request for Proposal shall be distributed; and

(3) The date when the Proposal shall be due to the Agency.

(b) The geographic service area for a new Corporation shall be based upon the number of small businesses in the area, unemployment levels and the lack of available debt financing for small businesses. The Director shall select the area which he or she believes to be most underserved, using the above described criteria.

(c) Within seven (7) calendar days following the due date for the Proposal the Director shall summarize the Proposals, and determine which Proposer is most likely to meet the Program goals specified in Corporations Code section 14002.

(d) Within thirty (30) calendar days following the Proposal due date, the Director shall present the information contained in subsection (c) to the entire Board.

(e) At the Board meeting where the presentation described in subsection (d) is presented, the Board shall take one of the following actions:

(1) Approve the recommendation of the Director, or if the Director presented more than one recommendation, approve one of the recommendations; or

(2) Not approve the recommendation of the Director, and instruct the Director to submit a new recommendation at a subsequent Board meeting; or

(3) Cancel the Proposal.

(f) If, pursuant to the procedures contained in subsection (e), the Board approves a recommendation of the Director, the Board shall adopt a reso-

lution creating a new Corporation. The resolution shall include the approval of the proposed articles of incorporation, and shall instruct the Director to file the articles with the Secretary of State.

(g) The Agency shall notify all Proposers of the Board's decision within five (5) calendar days.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14022, 14025(c), 14025(d), 14045, 14046 and 14050, Corporations Code.

HISTORY

1. New section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
2. Amendment filed 6–9–97 as an emergency; operative 6–9–97 (Register 97, No. 24). A Certificate of Compliance must be transmitted to OAL by 10–7–97 or emergency language will be repealed by operation of law on the following day.
3. Reinstatement of section heading and section as they existed prior to 6–9–97 emergency amendment by operation of Government Code section 11346.1(f) (Register 98, No. 30)
4. Amendment of section heading, section and NOTE filed 7–24–98; operative 7–24–98 pursuant to Government Code section 11343.4(d) (Register 98, No. 30).
5. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5061. Contents of Proposal.

(a) The Proposal shall consist of a cover sheet, evidence of experience, table of contents and information as set forth in subsection (d) below.

(b) The cover sheet of the Proposal shall be signed and dated by each of the entities or individuals which are submitting the Proposal, and shall contain the following information:

(1) Name and address of each entity or individual submitting the Proposal;

(2) The proposed location and service area of the Proposer;

(b) Evidence that Proposer has a minimum of two years' experience in small business finance assistance, or a request for waiver from this requirement, including the reasons for requesting the waiver.

(c) The Proposer shall prepare and submit a table of contents page which lists each of the items required in the Proposal, and the page number where it is located.

(d) The Proposal shall contain the following information:

(1) A business plan setting forth the proposed activities of the Proposer during the first year. The business plan will include activities financed from all sources.

(2) Letters of cooperation from organizations and individuals located within the geographic area to be served. The letters must indicate specific assistance which the organization or individual will provide to the Proposer.

(3) A description of the proposed facilities where the Proposer would be located. The description must include a map showing the location, a photograph of the building, the lease terms, square footage, and wheelchair accessibility.

(4) A description of the legal structure of the proposed Corporation. The Proposer must incorporate following designation as a Corporation. If the Proposer is already an established organization, it must acknowledge that upon designation as a Corporation, it will be necessary to incorporate a new legal organization, and that this organization must comply with all requirements of both the Law and the Public Benefit Corporation law.

(5) Proposed article of incorporation complying with Corporations Code section 14045.

(6) A description of the proposed staffing. For each proposed staff position, indicate the minimum experience, salary and proposed funding source. If the Proposer intends to select a specific person to fill any of the positions, include the resume of each proposed individual.

(7) A budget which shall consist of all proposed income and expenses of the Proposer during the first year following designation as a Corporation. The budget shall list each source of income for each cost category. Cost categories shall include, at a minimum:

(A) employees, with each proposed employee listed by job title and funding source;

(B) equipment;

(C) consultants, including legal and accounting;

(D) utilities;

(E) rent; and

(F) travel.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14002(b), 14045 and 14050, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No.21).
2. Editorial correction filed 2–16–83 (Register 83, No.8).
3. Repealer and new section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).
4. Amendment of subsections (a) and (d) filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5061.1. Corporate Filing of Articles, Bylaws and Operating Plans.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b) and (d)(5),14023(d),14024(c),14032, 14125(c),14128 and 14129(h) Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–6–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5061.2. Removal of Corporate Officers.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14035, Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No.8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5061.3. Continuous Relationship by Debtors.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14024(b),(6),14028.4, 14084 and 14170 Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No.8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5061.4. Conditional Grant Conditions.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023(a),(b),and (f), 14023.5(k), 14085, 14125(c), 14127 and 14129(h), Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5061.5. Corporate Portfolio Status Reports.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14023.5(k) and 14127, Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83. (Register 83, No.8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

Article 6. Leverage Requirements for Use of Reserve

§ 5070. Trust Fund Account Allocation; Default Penalties.

(a) The Agency and each Corporation shall annually negotiate and execute Corporate Contracts and Multi–party Contracts. As used in this sec-

tion, "Fiscal Year" means the period commencing July 1 and ending June 30 of the following year.

(b) Following the end of each Fiscal Year, the Agency shall calculate the Net Default rate for each Corporation. The Agency shall remove 5% of the funds from the trust fund account of a Corporation with a Net Default Rate not less than 3.5% and not greater than 5%. The Agency shall remove 10% of the funds from the trust fund account of a Corporation with a Net Default Rate greater than 5%. The Net Default Rate shall be calculated and defined as follows:

(1) Add the amount of money paid by the Agency for Guarantees and Farm Loans which were executed by the Corporation during the previous five Fiscal Years and which went into Default.

(2) Subtract from the subsection (b)(1) amount any recoveries received by the Agency on the Default Guarantees and Farm Loans during the previous five Fiscal Years.

(3) For each of a Corporation's five previous Fiscal Years, add the amount of Guarantees and Farm Loans made by the Corporation which are outstanding as of the end of each month of each year and divide the total amount for each year by twelve (12), "Average Annual Guarantees and Farm Loans".

(4) Calculate the sum of the Average Annual Guarantees and Farm Loans.

(5) Divide the subsection (b)(2) number by the subsection (b)(4) number. The resulting number is the Net Default Rate.

(c) Appropriations remaining in the Expansion Fund following the subsection (a) Allocations and default penalties collected pursuant to subsection (b) shall be Allocated as described below:

(1) Divide the dollar amount of outstanding Bonds, Farm Loans and Loans Guaranteed as of the end of the Fiscal Year (collectively referred to in this section as "Financings" of the Corporation) by the dollar amount of Financings of all Corporations. Multiply this number times .75.

(2) Divide the number of Financings of the Corporation by the number of Financings of all Corporations. Multiply this number times .25.

(3) Add the amount of Appropriation remaining in the Expansion Fund following the subsection (a) Allocations and the amount of default penalties removed from trust fund accounts pursuant to subsection (b).

(4) Add the (c)(1) and (c)(2) numbers. Multiply the resulting number by the subsection (c)(3) number and transfer that amount to the Corporation's trust fund account.

(d) No earlier than May 1 of any year, the Agency shall be authorized to transfer funds between trust fund accounts. Funds shall be removed from any trust fund account where the ratio of existing Bonds, Farm Loans and Guarantees to the amount of funds in the trust fund account is less than 2:1. Sufficient funds shall be removed to leave a ratio of 2:1.

(e) The funds removed from a trust fund account pursuant to subsection (d) shall be allocated to Corporations which did not have subsection (d) removals in the current Fiscal Year, defined in this section, respectively, as "Ineffective Funds" and "Effective Corporations." Ineffective Funds shall be allocated to Effective Corporations using the following formula:

(1) Divide the dollar amount of the outstanding Farm Loans and Guarantees executed by the Corporation as of April 30th of the current Fiscal Year by the dollar amount of outstanding Farm Loans and Guarantees executed by all Effective Corporations as of April 30 of the current Fiscal Year. Multiply this number times .75.

(2) Divide the number of Farm Loans and Guarantees executed by the Corporation by the number of Farm Loans and Guarantees executed by all Effective Corporations. Multiply this number times .25.

(3) Add the (e)(1) and (e)(2) numbers. Multiply the resulting number times the amount of Ineffective Funds and transfer that amount to the Corporation's trust fund account.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14036, 14038, 14041 and 14071, Corporations Code.

HISTORY

1. Amendment of article and section headings and new section filed 11–4–93 as an emergency; operative 11–4–93 (Register 93, No. 45). A Certificate of Compliance must be transmitted to OAL by 3–4–94 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 85, No. 26.
2. Certificate of Compliance as to 11–4–93 order transmitted to OAL 3–3–94 and filed 3–15–94 (Register 94, No. 11).
3. Repealer and new section filed 1–19–99 as an emergency; operative 1–19–99 (Register 99, No. 4). A Certificate of Compliance must be transmitted to OAL by 7–19–99 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of subsection (c)(2) (Register 99, No. 28).
5. Certificate of Compliance as to 1–19–99 order, including further amendment of subsection (b)(3), transmitted to OAL 6–3–99 and filed 7–9–99 (Register 99, No. 28).
6. Amendment of section heading and section filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of HISTORY 6 (Register 2005, No. 27).
8. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5071. Hearings.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023.5(b) and 14025, Corporations Code.

HISTORY

1. Editorial correction filed 2–16–83 (Register 83, No. 8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5072. Notice of Intent to Withdraw Funds.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b) and 14025, Corporations Code.

HISTORY

1. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5073. Temporary Withdrawal of Funds.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023(a), 14023.5(k) and 14025, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 2–016–83 (Register 83, No.8).
2. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5074. Findings and Conclusions.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14023(a), 14023.5(k) and 14025, Corporations Code.

HISTORY

1. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5075. Suspension.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b) and 14025, Corporations Code.

HISTORY

1. Order of Repeal filed 6–3–85 by OAL pursuant to Government Code Section 11349.7; effective thirtieth day thereafter (Register 85, No. 26).

§ 5076. Relief from Suspension.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Sections 14022(b), 14025 and 14026, Corporations Code.

HISTORY

1. Editorial correction of NOTE filed 5–19–82 (Register 82, No. 21).
2. Editorial correction of NOTE filed 2–16–83 (Register 83, No. 8).
3. Repealer of section filed 6–24–91; operative 7–24–91 (Register 91, No. 42).

§ 5077. Voting Limitation.

NOTE: Authority cited: Section 14022(b), Corporations Code. Reference: Section 14075, Corporations Code.

HISTORY

1. New section filed 12–13–79 as an emergency; effective upon filing (Register 79, No. 50). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 4–12–80.
2. Certificate of Compliance filed 4–10–80 (Register 80, No. 15).

3. Repealer filed 7–10–81; effective thirtieth day thereafter (Register 81, No. 28). Due to printing error, text inadvertently omitted in Register 80, No. 22; refer to Register 80, No. 15 for prior language.

Article 7. New Product Development

§ 5080. Corporation Eligibility to Participate in a Product Development Program.

NOTE: Authority cited: Sections 14022(b) and 14029.92, Corporations Code. Reference: Section 14029.9, Corporations Code.

HISTORY

1. New section filed 5–26–87; operative 6–25–87 (Register 87, No. 22).
2. Change without regulatory effect repealing article and section filed 11–29–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 49).

§ 5080.1. Definition of Person to Include Corporation.

NOTE: Authority cited: Sections 14022(b) and 14029.92, Corporations Code. Reference: Section 14010(w), Corporations Code.

HISTORY

1. New section filed 5–26–87; operative 6–25–87 (Register 87, No. 22).
2. Change without regulatory effect repealing section filed 11–29–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 49).

§ 5080.2. Allowable, Documented Costs.

NOTE: Authority cited: Sections 14022(b) and 14029.92, Corporations Code. Reference: Sections 14029.9 and 14029.92, Corporations Code.

HISTORY

1. New section filed 5–26–87; operative 6–25–87 (Register 87, No. 22).
2. Change without regulatory effect repealing section filed 11–29–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 49).

§ 5080.3. Allowable Costs and Terms of Venture Capital Agreement.

NOTE: Authority cited: Sections 14022(b) and 14029.92, Corporations Code. Reference: Sections 14029.9 and 14029.92, Corporations Code.

HISTORY

1. New section filed 5–26–87; operative 6–25–87 (Register 87, No. 22).
2. Change without regulatory effect repealing section filed 11–29–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 49).

§ 5080.4. Reporting Requirements.

NOTE: Authority cited: Sections 14022(b) and 14029.92, Corporations Code. Reference: Sections 14029.9, 14029.92 and 14127, Corporations Code.

HISTORY

1. New section filed 5–26–87; operative 6–25–87 (Register 87, No. 22).
2. Change without regulatory effect repealing section filed 11–29–93 pursuant to title 1, section 100, California Code of Regulations (Register 93, No. 49).

Article 8. Conflict of Interest Code Small Business Board and California Small Business Financial Development Corporations

§ 5101. General Provisions.

The Political Reform Act of 1974 (Government Code section 81000, *et seq.*) requires state and local government agencies to adopt and promulgate conflict of interest codes. The Fair Political Practices Commission has adopted a regulation (Title 2 California Code of Regulations section 18730) which contains the terms of a standard conflict of interest code, which can be incorporated by reference in an agency's code. After public notice and hearing, it may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of Title 2 California Code of Regulations section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. These regulations and the attached Appendices, designating officials and employees and establishing disclosure categories, shall constitute the conflict of interest code of the Small Business Board and California Small Business Financial Development Corporations.

Designated persons identified in Appendix A shall file statements of economic interests with the Business, Transportation and Housing Agency. Upon receipt of the statements from the Small Business Board, the Agency shall promptly make and retain a copy and forward the originals of the statements to the Fair Political Practices Commission. Statements for the Small Business Financial Development Corporations positions will be retained by the Agency.

Appendix A

Designated Persons

Persons in the following positions are designated persons and shall make the designated types of disclosures set forth in the disclosure categories listed opposite the position. A detailed description of each disclosure category is set out in Appendix B.

Designated Positions	*Disclosure Categories*
Members of Small Business Board	1
Directors/Members of the Board of California Small Business Financial Development Corporations	2
Officers of California Small Business Financial Development Corporations	2
Loan Committee Members of California Small Business Financial Development Corporations	2
Consultants	*

Appendix B

Disclosure Categories

1. Income from, investments in, and management positions with entities, profit or nonprofit, which:

(A) Have received in the past two years, are in receipt of, have applied for, are in the process of applying for, or which the official knows are planning to apply for within the next 12 months equity financing, direct loan or guarantee of a loan by a California Small Business Financial Development Corporation.

(B) Have received in the last two years, have applied for, are in the process of applying for, or which the official knows are planning to apply for within the next 12 months a contract with the California Business, Transportation and Housing Agency.

(C) Are banks, savings and loans, or other financial institutions of the type which lends funds guaranteed pursuant to the California Small Business Financial Development Corporation Law.

2. Income from, investments in, and management positions with entities, profit or nonprofit, which:

(A) Have received in the past two years, are in receipt of, have applied for, are in the process of applying for, or which the official knows are planning to apply for within the next 12 months equity financing, direct loan or guarantee of a loan by a California Small Business Financial Development Corporation in which the official is a board member, officer, staff, or loan committee member.

(B) Have received in the last two years, have applied for, are in the process of applying for, or which the official knows are planning to apply for within the next 12 months a contract to be a subcontractor with the California Small Business Financial Development Corporation in which the official is a board member, officer, staff, or loan committee member.

(C) Acting as lender which have received, are in receipt of, have applied for, or which the official knows are planning to apply for within the next 12 months a guarantee of payment from the California Small Business Financial Development Corporation in which the official is a board member, officer, or loan committee member.

(D) Are banks, savings and loans, or other financial institution of the type which lends funds guaranteed pursuant to the California Small Business Financial Development Corporation Law.

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*Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation:

The reporting of economic interests for consultants shall be determined on a case–by–case basis by the Director or his or her designee. The Director or his or her designee will determine the reporting requirements in writing, based on the

scope of the consultant's particular duties, assignments and/or deliverables (as defined in Title 2, California Code of Regulations, section 18700). The determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code.

NOTE: Authority: Section 14022(b), Corporations Code. Reference: Sections 14020–14026, and 14085–14087, Corporations Code; and Section 87300 *et seq.*, Government Code.

HISTORY

1. New article (section 5101 and Appendix) filed 3–3–82; effective thirtieth day thereafter. Approved by Fair Political Practices Commission 1–4–82 (Register 82, No. 10)
2. Amendment of section heading and text filed 12–2–91; operative 1–2–92. Submitted to OAL for printing only (Register 92, No. 9).
3. Amendment of article 8 heading, section and Appendices A and B filed 8–30–2002; operative 9–29–2002. Approved by Fair Political Practices Commission 6–24–2002 (Register 2002, No. 35).
4. Amendment of section and Appendix B filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Reinstatement of section as it existed prior to 12–27–2004 emergency amendment by operation of Government Code section 11346.1(f) (Register 2005, No. 27).
7. Change without regulatory effect amending general provisions and Appendix B filed 2–11–2008 pursuant to section 100, title 1, California Code of Regulations (Register 2008, No. 7).

Article 9. Farm Loans

§ 5110. Farm Loan Definitions.

In addition to the definitions set forth in Section 5000 of these regulations, and section 14010 of the Corporations Code, the following definitions apply to article 9:

(a) "Authorized Farm Costs" means the costs incurred by a Farm, including:

(1) Operating and production expenses, including the purchase, construction or repair of buildings, machinery, equipment and storage and drying facilities, the purchase of animals, seed and fertilizer, the purchase of real estate and the costs of improvement or repairs thereto.

(2) Costs associated with the purchase of real estate, including easements and rights–of–way to establish or enlarge a Farm.

(3) Costs associated with water development, soil conservation, forestation, drainage, pollution abatement and related measures.

(4) Disaster losses including actual losses incurred in connection with disaster damaged or destroyed farm property or production enterprises, or both, including annual operating and production expenses, construction and improvement of buildings and facilities, and land and water development.

(5) Refinancing debt including the costs associated with the issuance of such debt and lender fees and charges, where the debt to be refinanced was incurred for Authorized Farm Costs. No costs set forth in this clause shall be authorized unless the Farm Lender shall certify that, in the Farm Lender's opinion, sufficient collateral or cash flow exists to reasonably preclude the chance of loan losses.

(b) "Farm" means a business which is primarily engaged in producing crops, livestock products or aquatic organisms through the utilization and management of land, water, labor, capital and basic materials including seed, feed, fertilizer and fuel.

(c) "Farm Borrower" means a Farm which has applied for, or which has entered into, a Farm Borrower Agreement.

(d) "Farm Borrower Agreement" means a written loan agreement whereby the Farm Lender agrees to lend funds to the Farm Borrower to finance Authorized Farm Costs, and which includes at a minimum: a note, security agreement and loan agreement each consistent with commercial practices and containing the following:

(1) A list of Farm Borrower security for the Farm Borrower Loan and plans for at least an annual accounting for security.

(2) The Authorized Farm Costs for which loan funds shall be used.

(3) The interest rate, which shall not exceed four percent (4%) above the prime rate listed in the western edition of the Wall Street Journal on the date of the loan commitment.

(4) The term, which shall not exceed seven years, except for a Guaranteed Farm Borrower Loan. The term of a Guaranteed Farm Borrower Loan shall not exceed that authorized by USDA. The aggregate outstanding balance of loans with a remaining term to maturity in excess of eighty–four (84) months shall not comprise more than twenty–five percent (25%) of the Farm Lender's trust fund account assets.

(5) The loan amount, which shall not exceed the maximum amount allowed by the USDA.

(6) Default and Liquidation provisions which shall comply with Sections 5114 and 5115, respectively.

(7) Fees pursuant to section 5118.

(e) "Farm Borrower Loan" means a Term Loan or Line of Credit Loan from a Farm Lender to a Farm Borrower pursuant to a Farm Borrower Agreement. At least ninety percent (90%) of Farm Borrower Loans funded from the Corporation's trust fund account, calculated by dollar amount, must be guaranteed by the USDA. In determining the percentage, the numerator is the loan amount for outstanding Guaranteed Farm Borrower Loans, and the denominator is the loan amount of all outstanding Farm Borrower Loans.

(f) "Farm Lender" means a Corporation that has been approved by the USDA as a lender.

(g) "Farm Lender Credit Agreement" means a written agreement whereby the Agency agrees to lend funds to Farm Lender, for the purpose of funding Farm Borrower Loan(s). The Farm Lender Credit Agreement may be a Master Agreement, and will include provisions that require the Farm Lender to request disbursement of loan proceeds from the Agency only after the Farm Borrower Loan(s) and respective Farm Borrower Agreement(s) have been approved and are in effect. The Farm Lender Credit Agreement will also include provisions covering the following:

(1) Security. No funds shall be disbursed except to fund a previously approved Farm Borrower Agreement assigned as security to the Farm Lender Credit Agreement. As used in this subsection "assigned as security" means:

(A) For a Guaranteed Farm Borrower Loan, that the Agency is the Holder, or the Guaranteed portion has been sold at par value and the proceeds have been deposited in the trust fund account from which the funds originated.

(B) For a Nonguaranteed Farm Borrower Loan, the Farm Lender Credit Agreement is secured by assignment of all notes, security agreements and similar instruments contained in the Farm Borrower Agreement.

(2) The loan amount, which shall not exceed the total amount of Farm Borrower Loans authorized for the Farm Lender by the Director.

(3) The interest rate, which shall be two percent (2%) below the prime rate listed in the western edition of Wall Street Journal for each respective day for which funds are owed to the Agency.

(4) Repayment terms, which shall be based upon the repayment terms in the Farm Borrower Agreement(s) funded with proceeds from the Farm Lender Credit Agreement.

(h) "Farm Lender Disbursement Request" means a signed request for disbursement of trust funds under an existing Farm Lender Credit Agreement made in writing to the Agency by a Farm Lender in compliance with Section 5111.

(i) "Guarantee" means a signed commitment, issued by the USDA, to guarantee payment of all or part of a Farm Borrower Loan.

(j) "Guaranteed Farm Borrower Loan" means a Farm Borrower Loan which is in whole or part subject to the Guarantee.

(k) "Holder" means a person or an organization other than the Farm Lender who purchases all or part of the Guarantee portion of a Guaranteed Farm Borrower Loan.

(*l*) "Liquidation" means the exercise of rights provided for in the event of any Default under a Farm Borrower Agreement or the related Farm Lender Credit Agreement, including the right to foreclose in accordance

with the terms of any financing statement, security interest or similar instrument obtained or entered into in relation to such Farm Borrower Agreement or Farm Lender Credit Agreement.

(m) "Nonguaranteed Farm Borrower Loan" means a Farm Borrower Loan not subject to a Guarantee.

(n) "USDA" means the United States Department of Agriculture.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070(c) & (e), Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 92, No. 28.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5111. Disbursement of Farm Lender Loan Funds.

(a) No Farm Borrower Agreement shall be executed by a Corporation until the proposed Farm Borrower Loan has been reviewed by the Corporation's loan committee and approved by its board of directors, unless the Corporation's board of directors has delegated the authority to approve a proposed Farm Borrower Loan to the Corporation's loan committee. Approval of the Farm Borrower Loan shall be evidenced by adoption of a corporate resolution approving the loan. The Corporation shall retain the resolution and the minutes of loan committee and board of directors meetings at which the loan was discussed and approved, including any conditions placed on the loan.

(b) Disbursement of loan proceeds to the Farm Lender for Farm Borrower Loans will be made only if the Farm Lender is a party in good standing to an existing Farm Lender Credit Agreement.

(c) Within ten (10) calendar days of receiving a Farm Lender Disbursement Request for a previously approved Farm Borrower Loan, the Agency shall notify the Farm Lender of disbursement approval, provided:

(1) Funds are available in the trust fund account of the Farm Lender to meet the request contained in the Farm Lender Disbursement Request.

(2) The disbursement is in connection with an executed Farm Borrower Agreement which complies with section 5110(d), referred to in the remainder of this section as "Farm Borrower Loan".

(3) The disbursement request is consistent with the funding requirements of the related Farm Borrower Agreement. Evidence of the consistency consists of a budget showing amounts previously disbursed to the Farm Lender in connection with such Farm Borrower Loan, amount of loan proceeds lent by the Farm Lender to the Farm Borrower, and the date upon which it is projected that the money to be disbursed pursuant to this section shall be lent by the Farm Lender to the Farm Borrower.

(d) In any case where funds are disbursed to a Corporation pursuant to a Farm Lender Disbursement Request and the Corporation has failed to comply with subsection (a), the Agency shall immediately exercise all available legal remedies to recover from the Corporation the funds disbursed pursuant to the Farmer Lender Disbursement Request.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5112. Release of Farm Loan Funds.

(a) Farm Lender shall not lend funds received pursuant to a Farm Lender Credit Agreement to a Farm Borrower without complying with the following conditions precedent:

(1) For a Nonguaranteed Farm Borrower Loan, or for a Guaranteed Farm Borrower with a loan that cannot be legally assigned or sold, assignment to the Agency of the Farm Borrower Agreement note, together with an assignment of any financing statement, security interest or similar instrument obtained or entered into pursuant to the related Farm Borrower Agreement, perfected by a UCC–1 public notice.

(2) For a Guaranteed Farm Borrower Loan:

(A) A Guarantee has been executed, and either assigned to the Agency or sold pursuant to section 5116, and

(B) A certification by the Farm Lender that it has complied with or has taken all actions which are in its opinion necessary to comply with any conditions precedent to the issuance of such Guarantee required by USDA; provided, however, that for the purposes of this section, payment of funds to the Farm Borrower shall not be deemed to be such a condition.

(b) Farm Lender shall provide evidence of compliance with subsection (a) to the Agency within seven (7) days of disbursement of funds to a Farm Borrower.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment of subsections (a) and (b) filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5112.5. Payment of Funds to Farm Borrower.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14131(c), Corporations Code.

HISTORY

1. Certificate of Compliance as to 9–19–88 order including new Section 5112.5 filed 2–8–89 (Register 89, No. 8).
2. Repealer filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day.

§ 5113. Accounting and Reporting.

(a) Farm Lender shall establish an account which shall be used solely to record disbursements and repayments for Farm Borrower Loans and Farm Lender Loans. The account shall have separate sub–ledgers which shall correspond to each specific Farm Lender Credit Agreement and Farm Borrower Agreement. Funds shall only be withdrawn from Farm Lender Credit Agreement sub–ledgers for subsequent payment to a Farm Borrower, for payments to the trust fund account or upon written authorization of the Agency. Funds shall only be withdrawn from Farm Borrow-

er Agreement sub–ledgers for payments to the trust fund account, to the Holder or upon written authorization of the Agency.

(b) The Farm Lender shall reconcile the two sets of sub–ledgers monthly. One set shall consist of all activities for each Farm Borrower Loan, including payment and repayment information. Farm Lender shall maintain these reconciliations at its principal place of business. The second reconciliation shall consist of all Farm Lender Loan activity. Farm Lender shall mail these reconciliations to the Agency monthly.

(c) All records established and maintained in connection with the account and its sub–ledgers shall be available upon reasonable notice for audit by the Agency or its designee, and shall be maintained for a three (3) year period following the expiration of the related Farm Lender Credit Agreement or Farm Borrower Agreement.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment of subsections (a) and (c) filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5114. Defaults.

(a) A Default of a Farm Borrower Agreement shall be a default of outstanding trust fund account funds under the related Farm Lender Credit Agreement. Farm Lender shall provide the Agency with written notice that a Default has occurred within fourteen (14) days of either failure by the Farm Borrower to make payment at loan maturity or filing for bankruptcy by Farm Borrower.

(b) With respect to a Default on a Guaranteed Farm Borrower Loans, the procedures to be followed by a Farm Lender shall be those specified by USDA. If no such procedures exist, the procedures specified in subsection (c) shall apply.

(c) With respect to a Default on a Nonguaranteed Farm Borrower Loans, the procedures to be followed by a Farm Lender shall be set forth in the Farm Borrower Agreement and the related Farm Lender Credit Agreement, and shall include the following:

(1) A meeting shall be arranged by the Farm Lender with the Farm Borrower upon occurrence of a Default in order to resolve the problem. Actions taken by the Farm Lender may include, the following:

(A) Deferment of principal payments.

(B) An additional temporary loan by the Farm Lender to bring the account current.

(C) Reamortization of or rescheduling the payments on the loan.

(D) Reorganization.

(E) Subsequent loan guarantees.

(F) Changes in the interest rate, upon approval of the Agency.

(2) The Farm Lender shall negotiate in good faith in an attempt to resolve any problem to permit the Farm Borrower to cure a Default; provided that, in the opinion of the Farm Lender, the proposed resolution is economically feasible.

(3) If, within ninety (90) days following receipt by the Agency of the notice provided for in subsection (a), the Farm Lender is unable to resolve to its satisfaction any Default, then Farm Lender shall institute Liquidation proceedings.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment of subsections (a), (c)–(c)(1) and (c)(3) filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5115. Liquidation.

(a) With respect to Guaranteed Farm Borrower Loans, Liquidation shall follow the procedures required by USDA; provided, however, that any reports made to USDA in connection with such Liquidation shall also be given to the Agency. If no such procedures exist, the procedures specified in subsection (b) shall apply.

(b) With respect to Liquidation of a Nonguaranteed Farm Borrower Loan, a Liquidation plan shall be prepared by the Farm Lender and delivered to the Agency. The Liquidation plan shall specify the steps Farm Lender intends to take for Liquidation of the Farm Borrower Loan, including proposed costs. Unless the Farm Borrower receives written objections to the Liquidation plan from the Agency within fourteen days of mailing the plan to the Agency, the plan shall be deemed approved by the Agency. In the event Farm Lender receives a written objection to the plan from the Agency within the fourteen days, the Agency and Farm Lender shall negotiate a mutually acceptable Liquidation plan.

(c) Liquidation recoveries made in connection with Nonguaranteed Farm Borrower Loans shall be applied in the following order of priority.

(1) To pay Liquidation costs approved by the Agency.

(2) To pay accrued interest and late fees.

(3) To pay principal.

(4) To pay fees owed to the Farm Lender, pursuant to Section 5118.

(d) With respect to Liquidation in connection with either Guaranteed or Nonguaranteed Farm Borrower Loans, the Farm Lender shall not initiate any judicial remedy without the prior written approval of the Agency.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of subsection (b) and NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5116. Sale of the Guaranteed Portion of the Farm Borrower Loan.

Farm Lender is authorized to negotiate the sale of the Guaranteed portion of the Farm Borrower Loan, if allowed by law, together with the Guarantee, to third parties. The sale shall result in the receipt by the Farm Lender of a sum no less than the outstanding balance owed on the Guaranteed portion of the Farm Borrower Loan being sold. The Farm Lender shall deposit the funds received into the trust fund account from which the loan funds were disbursed.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL

by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.

2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5117. Payments.

(a) Payments received from repayment of a Farm Borrower Loan shall be allocated to Farm Lender, trust fund account and, if applicable Holder, based upon the percentage ownership of the Farm Borrower Loan. Therefore, if the Holder owns 90% and the trust fund account owns the remaining 10%, then the principal and interest payments are divided 90/10, except that the portion of the interest owed the trust fund account shall be based upon the Farm Lender Credit Agreement interest rate (two points below prime) and not the Farm Borrower Agreement (three points above prime). Payment shall be received by the trust fund account and if applicable Holder within forty–five (45) days of the Farm Lender receiving the funds from Farm Borrower.

(b) The Agency shall periodically audit Farm Lender's calculation of interest and principal owed under Farm Lender Credit Agreement, and send written notice to Farm Lender specifying any error in the calculation, and the amount of the discrepancy. If the letter specifies that Farm Lender owes additional funds, Farm Lender shall pay funds to the appropriate trust fund account within seven days of receiving the letter from the Agency. If the letter specifies that Farm Lender paid more than was owed, Farm Lender shall apply the overpayment to the next payment due to the Agency.

(c) Any sum disbursed to the Farm Lender pursuant to section 5111 and not lent to Farm Borrower within six (6) months from the date of such disbursement shall be repaid by Farm Lender within five (5) working days of notification by the Agency, and the Farm Lender shall have no further rights with respect to such funds.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Amendment filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

§ 5118. Fees.

The Farm Lender shall be authorized to charge the Farm Borrower a fee of two percent (2%) of the amount of the Farm Borrower Loan, of which nine–tenths of a percent (.9%) shall be paid to USDA on any Guaranteed Farm Borrower Loan. The net servicing fee to the Farm Lender is thus two percent (2%) for a Nonguaranteed Farm Borrower Loan and one point one percent (1.1%) for a Guaranteed Farm Borrower Loan.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5119. Use of Reserve Funds.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14067 and 14070, Corporations Code.

HISTORY

1. Repealer and new section filed 2–1–94 as an emergency; operative 2–1–94 (Register 94, No. 5). A Certificate of Compliance must be transmitted to OAL by 8–1–94 pursuant to Corporations Code section 14024 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 89, No. 8.
2. Amendment filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction of HISTORY 2 (Register 2005, No. 27).
4. Certificate of Compliance as to 12–27–2004 order, including amendment of NOTE, transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).
5. Repealer filed 8–4–2008 as an emergency; operative 8–4–2008 (Register 2008, No. 32). A Certificate of Compliance must be transmitted to OAL by 2–2–2009 or emergency language will be repealed by operation of law on the following day.

Article 10. Energy Conservation Loan Demonstration Program Procedures

§ 5250. Definitions.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14005, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5250, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Change without regulatory effect amending section filed 9–3–91 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 3).
5. Repealer of article 10 (sections 5250–5258) and section filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5251. Eligibility.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14005, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5251, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.

5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5252. Loan Terms.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14005, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5252, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5253. Application Content.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14005, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5253, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5254. Application Process.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Sections 14005 and 14049, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5254, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5255. Corporation Review.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Sections 14005 and 14049, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5255, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5256. Energy Extension Service Review.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14005, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5256, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5257. Office Review and Action.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Sections 14005 and 14049, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5257, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

§ 5258. Loan Disbursement.

NOTE: Authority cited: Sections 14022(b) and 14028.5, Corporations Code. Reference: Section 14005, Corporations Code; and Chapter 1339, Statutes of 1986.

HISTORY

1. New section filed 7–1–88 as an emergency; operative 7–1–88 (Register 88, No. 28). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 12–28–88.
2. New section with amendment refiled 10–7–88 as an emergency; operative 10–7–88 (Register 88, No. 43). A Certificate of Compliance must be transmitted to OAL within 180 days or Section 5258, as adopted and amended by emergency action, will be repealed on 4–5–89.
3. Certificate of Compliance filed 2–7–89 (Register 89, No. 11).
4. Repealer filed 12–27–2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12–27–2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6–27–2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12–27–2004 order transmitted to OAL 5–25–2005 and filed 7–7–2005 (Register 2005, No. 27).

Article 11. Hazardous Waste Reduction Loan Program

§ 5260. Definitions.

In addition to the definitions provided in Section 5000 of Title 10 of these regulations, the following supplemental definitions shall govern construction of this Article and the Code:

(a) "Act" means Article 13 (commencing with Section 14095) of Chapter 1 of Part 5 of Division 3 of Title 1 of the Corporations Code.

(b) "CEQA" means the California Environmental Quality Act as set forth in Division 13 (commencing with Section 21000) of the Public Resources Code.

(c) "DTSC" means the California Department of Toxic Substances Control.

(d) "Environmental Audit" means an investigation into all variables, including the Waste Reduction Borrower's production operations and the Waste Reduction Borrower's compliance with federal, state and local environmental laws, regulations and rulings, which would indicate whether property is, or is likely to become, contaminated with Waste.

(e) "Identification Number" means a number assigned pursuant to Title 22, Section 66262.12 of the California Code of Regulations.

(f) "Surplus Money Investment Fund" means the fund established pursuant to Government Code Section 16471.

(g) "Useful Life" means the estimated period during which the Waste Reduction practice is expected to achieve a net reduction in Waste generated or lessen the hazardous properties of the Waste generated.

(h) "Waste" means waste or a combination of wastes as defined in Health and Safety Code Sections 25115 and 25117.

(i) "Waste Reduction" means any production practice which either achieves a net reduction in Waste generated or lessens the hazardous properties of the Waste generated.

(j) "Waste Reduction Applicant" means a party which produces Waste and is applying for a Waste Reduction Loan.

(k) "Waste Reduction Application" means the application referred to in Section 5265.

(*l*) "Waste Reduction Borrower" means a Waste Reduction Applicant whose application for a Waste Reduction Loan has been approved and who has entered into a Waste Reduction Loan Agreement.

(m) "Waste Reduction Loan" means a loan made in accordance with the Act and Article 11 of Chapter 7 of Title 10 of these regulations.

(n) "Waste Reduction Loan Agreement" means any agreement entered into between the Agency and a Waste Reduction Borrower for a Waste Reduction Loan.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14095, 14096, 14097 and 14098, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Change without regulatory effect amending section filed 9-3-91 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 3).
4. Repealer of article heading and amendment of section filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of HISTORY 4 (Register 2005, No. 27).
6. Certificate of Compliance as to 12-27-2004 order, including new article heading and amendment of subsections (a) and (e) and of NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5261. Waste Reduction Borrower Eligibility.

Subject to all other provisions of the Act and these regulations, a Waste Reduction Applicant shall be eligible for a Waste Reduction Loan when all the following conditions are met:

(a) It has been assigned an Identification Number.

(b) It is an existing, viable, creditworthy business, as determined by a Corporation or the Agency.

(c) The funding request is for Waste Reduction, as approved by DTSC.

(d) The Agency determines that an adequate source of repayment and collateral exists to secure the Waste Reduction Loan.

(e) It qualifies as a small business pursuant to Section 14010(g) of the Code.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14095, 14097 and 14098, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of subsections (b), (e) and NOTE filed 11-22-93 as an emergency; operative 11-22-93 (Register 93, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-6-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 11-22-93 order transmitted to OAL 3-3-94 with amendment of NOTE and filed 4-13-94 (Register 94, No. 15).
5. Amendment of subsections (b)-(d) filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12-27-2004 order transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5262. Waste Reduction Loan Terms.

(a) Except as provided in subsection (b), the terms and conditions of a Waste Reduction Loan shall include all of the following:

(1) An interest rate equal to the most recent Surplus Money Investment Fund rate.

(2) A maximum Waste Reduction Loan amount of one hundred fifty thousand dollars ($150,000).

(3) A minimum Waste Reduction Loan amount of twenty thousand dollars ($20,000).

(4) A Waste Reduction Loan term not to exceed the Useful Life of the project, equipment or facilities to be acquired using the proceeds of the Waste Reduction Loan, or seven (7) years, whichever is less.

(5) A Waste Reduction Loan fee of two percent (2%) of the amount of the Waste Reduction Loan to be paid to the Agency upon initial disbursement of moneys pursuant to any Waste Reduction Loan Agreement.

(6) In the event of an appraisal pursuant to Section 5267(b), the Agency shall be authorized to require the Waste Reduction Loan applicant to pay the appraisal costs as a part of the Waste Reduction Loan or as otherwise agreed upon between the Agency and the Waste Reduction Applicant.

(7) Security and collateral, and conditions pertaining thereto, for the Waste Reduction Loan, as determined by the Agency.

(8) Late charges in the event of a Default.

(9) No other source of funding is available, or any other source of funding is only available with the partial funding by the Hazardous Waste Reduction Loan Program.

(b) In any case where the availability of funding from the California Loans for Environmental Assistance Now ("CLEAN") is contingent upon a Waste Reduction Loan, the Agency shall be authorized to approve a Waste Reduction Loan in the form of a letter of credit. The terms and conditions of a Waste Reduction Loan in the form of a letter of credit shall include all of the following:

(1) A maximum Waste Reduction Loan amount of one hundred fifty thousand dollars ($150,000).

(2) A minimum Waste Reduction Loan amount of twenty thousand dollars ($20,000).

(3) The Waste Reduction Loan does not exceed ten percent (10%) of the entire cost of the project to be funded, including all funding sources.

(4) A Waste Reduction Loan term not to exceed the term of the loan for which the Waste Reduction Loan serves as a letter of credit.

(5) A Waste Reduction Loan fee of two percent (2%) of the amount of Waste Reduction Loan to be paid to the Agency upon execution of the Waste Reduction Agreement.

(6) In the event of an appraisal pursuant to Section 5267(b), the Agency shall be authorized to require the Waste Reduction Loan applicant to pay the appraisal costs as a part of the Waste Reduction Loan or as otherwise agreed upon between the Agency and the Waste Reduction Applicant.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14097, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of section and NOTE filed 11-22-93 as an emergency; operative 11-22-93 (Register 93, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-6-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 11-22-93 order transmitted to OAL 3-3-94 with amendment of NOTE and filed 4-13-94 (Register 94, No. 15).
5. Amendment of subsections (a)(5)-(7) and repealer of subsections (b)-(b)(6) filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12-27-2004 order, including new subsections (b)-(b)(6), transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5263. Fees.

In consideration for undertaking actions in accordance with these regulations, and for assisting the Agency in all other matters regarding any Waste Reduction Loan, including Defaults, a Corporation shall receive from the Agency a fee amount to be negotiated between the Corporation and the Agency, and approved by the Board.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14097, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2005, No. 27).
5. Certificate of Compliance as to 12-27-2004 order, including amendment of NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5264. Waste Reduction Application Availability and Completion Review.

(a) Waste Reduction Applications shall be available from, and the Waste Reduction Applicant shall submit one (1) signed Waste Reduction Application to, the following address:

BUSINESS, TRANSPORTATION AND HOUSING AGENCY
980 9TH STREET, SUITE 2450
SACRAMENTO, CALIFORNIA 95814
ATTENTION: WASTE REDUCTION PROGRAM.

The Waste Reduction Application shall contain information in accordance with Section 5265.

(b) The Agency shall review each Waste Reduction Application to determine whether the Waste Reduction Application is complete. No later than ten (10) days following receipt of the Waste Reduction Application, the Agency shall either:

(1) Send a letter to the Waste Reduction Applicant indicating that the Waste Reduction Application is incomplete and specifying the steps, if any, which the Waste Reduction Applicant must take to correct identified deficiencies; or

(2) Send a letter to the Waste Reduction Applicant indicating that the Waste Reduction Application is complete.

(c) When the Agency acts pursuant to (b)(2) of this Section 5264, it shall (1) send a copy of the Waste Reduction Application to DTSC for review and action pursuant to Section 5266 and (2) either send a copy of the Waste Reduction Application to a Corporation for review and action pursuant to Section 5267 or, in the case of a letter of credit, the Agency itself will conduct the Section 5267 review.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14095, 14097 and 14098, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of subsection (c) and NOTE filed 11-22-93 as an emergency; operative 11-22-93 (Register 93, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-6-94 or emergency language will be repealed by operation of law on the following day.
4. Change without regulatory effect amending subsection (a) filed 2-7-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
5. Certificate of Compliance as to 11-22-93 order transmitted to OAL 3-3-94 with amendment of NOTE and filed 4-13-94 (Register 94, No. 15).
6. Amendment filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of HISTORY 6 (Register 2005, No. 27).
8. Certificate of Compliance as to 12-27-2004 order transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5265. Waste Reduction Application Content.

A Waste Reduction Application shall contain all of the following:

(a) The name, address and telephone number of the Waste Reduction Applicant's principal contact person in connection with the request for a Waste Reduction Loan;

(b) Information regarding the Waste Reduction for which funding is being requested, including:

(1) The Waste Reduction description;

(2) The Waste Reduction location;

(3) A description of the Waste to be reduced;

(4) The Waste Reduction components and costs; and

(5) Identification of any required federal, state or local permits;

(c) Information demonstrating compliance with the applicable terms, conditions and requirements of Section 5261;

(d) A statement by the Waste Reduction Applicant that it is in compliance with all local, state and federal laws, regulations, requirements and rules, including CEQA and all other environmental laws, regulations, requirements and rules;

(e) Information demonstrating that the Waste Reduction Applicant is able to provide adequate security, and repay the Waste Reduction Loan. "Security," as used herein, means a first lien on any equipment purchased with loan proceeds, first beneficiary interest in the life insurance policies of key Waste Reduction Applicant personnel, or other interests in real or personal property;

(f) Waste Reduction Loan amount and term;

(g) The Waste Reduction Applicant's current financial statement and, if available, the financial statements for the previous two (2) years; and

(h) All permits, official actions and exhibits thereto, secured in accordance with CEQA, or taken in connection with the Waste Reduction Application.

NOTE: Authority cited: Sections 14022(b) and 14148, Corporations Code. Reference: Sections 14140 and 14142, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).

§ 5266. DTSC Approval.

(a) Pursuant to Section 5264(c)(1), the Agency shall send to DTSC for review and action a copy of the completed Waste Reduction Application received by the Agency.

(b) Upon completion of its review, DTSC shall return to the Agency the Waste Reduction Application, together with DTSC's determination regarding funding of the Waste Reduction Application.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14097 and 14098, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of section heading and section filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2005, No. 27).
5. Certificate of Compliance as to 12-27-2004 order, including amendment of NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5267. Corporation (or Agency) Approval.

(a) Pursuant to Section 5264(c)(2), except for letters of credit, the Agency shall send a copy of a complete Waste Reduction Application to a Corporation.

(b) The Corporation shall be authorized to review the Waste Reduction Application and investigate the Waste Reduction Applicant, including procuring a commercial credit report and obtaining an appraisal of any real property used as security. The Corporation shall render an opinion as to whether the Waste Reduction Applicant has the ability to repay and secure the Waste Reduction Loan on the terms and conditions required by these regulations and requested by the Waste Reduction Applicant.

(c) Upon completion of its review pursuant to this Section, the Corporation shall return to the Agency the Waste Reduction Application, together with the Corporation's recommendation regarding funding of the Waste Reduction Application.

(d) In the case of a letter of credit, the Agency shall conduct the subsection (b) analysis.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14097, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of subsections (a), (d) and NOTE filed filed 11-22-93 as an emergency; operative 11-22-93 (Register 93, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-6-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 11-22-93 order transmitted to OAL 3-3-94 with amendment of NOTE and filed 4-13-94 (Register 94, No. 15).
5. Amendment of section heading and section filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12-27-2004 order transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5268. Environmental Audit.

The Agency shall prepare or cause to be prepared an Environmental Audit for each Waste Reduction Application.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14097, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of section and NOTE filed 11-22-93 as an emergency; operative 11-22-93 (Register 93, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-6-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 11-22-93 order transmitted to OAL 3-3-94 with amendment of NOTE and filed 4-13-94 (Register 94, No. 15).
5. Amendment filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12-27-2004 order transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5269. Agency Approval.

(a) Upon receipt of the material obtained by the Agency pursuant to sections 5266, 5267 and 5268, the Agency shall approve the Waste Reduction Loan Application when it finds all of the following requirements are met:

(1) DTSC has approved the Waste Reduction Application after reviewing it pursuant to Section 5266.

(2) A Corporation, or in the case of a letter of credit, the Agency, has recommended approval after undertaking the review required by Section 5267.

(3) The Environmental Audit made in accordance with Section 5268 supports or does not materially affect the decision to make the Waste Reduction Loan.

(4) The Agency determines that the collateral and the source of repayment are sufficient for the proposed Waste Reduction Loan.

(5) The Agency determines that funds are available to meet the funding request.

(b) Where any of the conditions and requirements of this Section have not been met, the Agency shall deny the Waste Reduction Application and determine what specific actions, if any, the Waste Reduction Applicant must take to obtain further Agency evaluation and review of the Waste Reduction Application.

(c) No later than sixty (60) days from the date upon which the Agency mails the letter pursuant to Section 5264(b)(2), the Agency shall notify the Waste Reduction Applicant of the Agency's loan decision, along with any explanation required by subsection (b) above.

(d) If the Agency approves the Waste Reduction Loan then it shall be authorized to enter into a Waste Reduction Loan Agreement which embodies the terms specified in Section 5262.

(e) If the Agency denies the Waste Reduction Application, the Waste Reduction Applicant shall have no right to administratively appeal the decision but may reapply at any time.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Sections 14095, 14097 and 14098, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment of subsections (a), (a)(2)-(3) and NOTE filed 11-22-93 as an emergency; operative 11-22-93 (Register 93, No. 49). A Certificate of Compliance must be transmitted to OAL by 4-6-94 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 11-22-93 order transmitted to OAL 3-3-94 with amendment of NOTE and filed 4-13-94 (Register 94, No. 15).
5. Amendment of section heading and section filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2005, No. 27).
7. Certificate of Compliance as to 12-27-2004 order transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

§ 5270. Loan Disbursement.

Following the execution of a Waste Reduction Loan Agreement, the Agency shall disburse monies as follows.

(a) The Borrower shall submit to the Agency signed invoices for acquisition and installation of the Waste Reduction measures included in the Waste Reduction Loan Agreement.

(b) Upon receipt of the signed invoice, the Agency shall disburse Waste Reduction Loan funds to the Waste Reduction Borrower.

(c) All work funded with loan proceeds shall be performed by a licensed contractor. "Licensed Contractor" means a contractor, as defined in section 7026 of the Business and Professions Code, who has been li-

censed pursuant to sections 7065 to 7077 of the Business and Professions Code.

NOTE: Authority cited: Section 14024, Corporations Code. Reference: Section 14097, Corporations Code.

HISTORY

1. New section filed 11-7-88 as an emergency; operative 11-7-88 (Register 88, No. 46). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 5-6-89.
2. Certificate of Compliance transmitted to OAL 2-27-89 and filed 3-29-89 (Register 89, No. 15).
3. Amendment filed 12-27-2004 as a deemed emergency pursuant to Corporations Code section 14024; operative 12-27-2004 (Register 2004, No. 53). A Certificate of Compliance must be transmitted to OAL by 6-27-2005 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of HISTORY 3 (Register 2005, No. 27).
5. Certificate of Compliance as to 12-27-2004 order, including amendment of subsection (c) and NOTE, transmitted to OAL 5-25-2005 and filed 7-7-2005 (Register 2005, No. 27).

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Title 10. Investment

Chapter 7.1. Business, Transportation and Housing Agency: Metal Plating Facility Loan Guarantees

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Chapter 7.1. Business, Transportation and Housing Agency: Metal Plating Facility Loan Guarantees

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Chapter 7.1. Business, Transportation and Housing Agency: Metal Plating Facility Loan Guarantees

Article 1. Metal Plating Facility Loan Guarantees

§ 5280. Definitions.

In addition to the definitions contained in Public Resource Code section 42100, the following supplemental definitions shall govern the construction of this chapter:

(a) "Act" means Article 1 (commencing with section 42100) of Chapter 2 of Part 3 of Division 30 of the Public Resources Code.

(b) "Air District" means the local Air Quality Management District or Air Pollution Control District.

(c) "Application" means all of the information required by a corporation in order to determine whether to offer a borrower a guarantee.

(d) "Board of Directors" means the governing board of a corporation established pursuant to Corporations Code section 14055.

(e) "Borrower" means an eligible business that has received a commitment for a loan, or has prepared an application. In order to be an "eligible business", the business must meet all of the eligibility requirements defined in section 5281.

(f) "CEQA" means the California Environmental Quality Act as set forth in Division 13 (commencing with section 21000) of the Public Resources Code.

(g) "Collateral" means those personal and business assets of the borrower and guarantor subject to a lien under the loan.

(h) "Collection guarantee" means a guarantee of a specified percentage of net loan principal and ninety (90) days interest at the same percentage. "Net loan principal" as used in this paragraph means the amount of loan principal remaining outstanding after the lender has fully complied with the collection procedures in section 5286.

(i) "Corporation" means a Financial Development Corporation formed under the California Small Business Financial Development Corporation Law (Chapter 1 [commencing with section 14000], Part 5, Division 3, Corporations Code).

(j) "Default" means either a delinquency which has not been cured within ninety (90) days, or that the borrower is in bankruptcy.

(k) "Delinquency" means the failure of the borrower to make any payment when due, pursuant to the terms of the loan, except for any principal payment due at the maturity of the loan.

(*l*) "Demand" means a request for payment by a lender to a corporation pursuant to section 5285.

(m) "Environmental audit" means an investigation that may be required by a lender or a corporation into the applicant's operations and compliance with federal, state and local environmental laws, regulations and rulings, which would indicate whether the facility is, or is likely to become, contaminated.

(n) "Environmental control equipment" means equipment or technologies that will enable the borrower to meet new or exceed existing regulatory requirements, or both, and implement additional pollution prevention and emission reduction opportunities.

(o) "Guarantee" means a written agreement to warrant the repayment of a portion of a loan or payment of all or a portion of a claim, with repayment from the Chrome Plating Pollution Prevention Fund established by Public Resources Code section 42102. Every guarantee of a loan shall be either a collection guarantee or a loan guarantee.

(p) "Hazardous waste" means waste or a combination of wastes as defined in Health and Safety Code sections 25115 and 25117.

(q) "Identification number" means a number assigned pursuant to Title 22, section 66262.12 of the California Code of Regulations.

(r) "Lender" means a banking organization, including national banks and trust companies and state chartered commercial banks, savings and loan associations, credit unions, state insurance companies, mutual insurance companies, and other banking, lending, retirement, and insurance organizations, authorized to conduct business in California.

(s) "Loan" means a loan by a lender to a borrower, which is guaranteed pursuant to section 5284, made for the purpose of purchasing environmental control equipment.

(t) "Loan agreement" means an agreement for a loan entered into between a lender and a borrower that is guaranteed pursuant to section 5284.

(u) "Loan committee" means a committee established pursuant to Corporations Code section 14060 to review applications for guarantees and make recommendations to the board of directors.

(v) "Loan guarantee" means a guarantee of a specified percentage of loan principal and ninety (90) days interest at the same percentage.

(w) "NAICS" means North American Industrial Classification System code published by the United States Office of Management and Budget, 1997 edition.

(x) "Reviewing agencies" means the Air Board or Air District, the Department, and the Water Board.

(y) "Toxic air contaminant" means an air pollutant that may cause or contribute to an increase in mortality or in serious illness, or which may pose a present or potential hazard to human health. For the purposes of this article, toxic air contaminant means a substance identified by the Air Resources Board including, but not limited to, hexavalent chromium; nickel and nickel compounds; cadmium and cadmium compounds, and, copper and copper compounds.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42100, 42101, 42102.4 and 42103, Public Resources Code.

HISTORY

1. New chapter 7.1, article 1 (sections 5280–5286) and section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

§ 5281. Borrower Eligibility.

Subject to all other provisions of the act and these regulations, an applicant shall be eligible for a Metal Plating Loan Guarantee when all the following conditions are met:

(a) The applicant has been assigned an identification number.

(b) The applicant is an existing, viable business with the ability to repay a loan, as determined by a corporation or a lender.

(c) The loan request is for funds to purchase and install environmental control equipment, as approved by the Air Board or Air District, Department, or Water Board.

(d) The lender and the corporation determine that an adequate source of repayment and collateral exists to secure the loan.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42101, 42101.1, 42101.3 and 42103, Public Resources Code.

HISTORY

1. New section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

§ 5282. Application Content.

A Metal Plating Loan Guarantee application shall contain all of the following:

(a) Information regarding the operation, ownership and location for which the application is being submitted, including:

(1) The name, address and telephone number of the applicant's principal contact person in connection with the request for a guarantee.

(2) A description of the nature of the business and/or activities conducted by the applicant, including descriptions of how the business meets the eligibility requirements in section 5281(a), (b), and (c), and Public Resources Code section 42101.1.

(3) The name, mailing address, and location, including latitude and longitude of the facility for which the application is submitted.

(4) Up to four NAICS codes which best reflect the principal products or services provided by the facility.

(5) The operator's name, address, telephone number, and ownership status.

(6) The name, address, and phone number of the owner of the facility.

(b) Information regarding the reduction of emissions, releases and/or hazardous waste for which funding is being requested, including:

(1) Specification of the hazardous wastes listed or designated under Chapter 11 of Title 22 to be transferred, treated, stored, at the facility, an estimate of the quantity of such wastes to be transferred, treated, or stored, and a general description of the processes to be used for such wastes.

(2) A description and quantity of the emission, releases or hazardous waste to be reduced.

(3) A scale drawing of the facility showing the location of present and future treatment, storage, and disposal areas.

(4) Photographs of the facility clearly delineating all existing structures; existing treatment, storage, and disposal areas; and sites of future treatment, storage, and disposal areas.

(5) A description of the processes to be used for transferring, treating, storing, and disposing of hazardous waste, and the design capacity of these items.

(6) The location of where the emissions, releases, or hazardous waste will be reduced.

(7) The location's proximity to any sensitive receptors or residential areas.

(8) A description and diagram of the environmental control equipment to be purchased and its associated costs.

(9) Identification of any required federal, state, or local permits.

(c) Information demonstrating compliance with the applicable terms, conditions, and requirements of section 5281.

(d) A statement by the applicant that it is in compliance with all local, state and federal laws, regulations, requirements and rules, including CEQA and all other environmental laws, regulations, requirements and rules.

(e) All permits, official actions and exhibits thereto, secured in accordance with CEQA, or taken in connection with the application.

(f) A copy of the environmental audit, if one is required by the lender or the corporation.

(g) A certification by the applicant that the facility meets one of the conditions specified in section 5281(c).

(h) Information demonstrating that the applicant is able to provide adequate security, and repay the loan. "Security," as used herein, means a first lien on any equipment purchased with loan proceeds, first beneficiary interest in the life insurance policies of key applicant personnel, or other interests in real or personal property. As used herein, "key applicant personnel" means a person(s) without whom, in the judgment of the lender, the business would fail.

(i) All financial information required by the lender for the purpose of determining the applicant's worthiness for a loan.

(j) The loan amount and term.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42101, 42101.1, 42101.3 and 42103, Public Resources Code.

HISTORY

1. New section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

§ 5283. Guarantee Procedures.

Upon receipt of a completed application from a potential borrower applying for a guarantee, the corporation shall review and process the application in accordance with the following procedures:

(a) Before considering whether to approve a guarantee, the corporation shall provide the reviewing agencies a copy of the application. Upon completion of their review, each reviewing agency shall return to the corporation the application, together with their determination regarding approval of the application.

(1) No later than 30 calendar days after receipt of an application, the reviewing agencies shall review the application and notify the applicant in writing whether the application is complete.

(2) If any reviewing agency deems the application incomplete, the reviewing agency shall provide a written notice to the applicant and corporation and specify those parts of the application which are incomplete and shall indicate the manner in which they can be made complete, including a list and thorough description of the specific information needed to complete the application. The reviewing agency shall specify in the notice of deficiency a date for submitting the necessary information. The applicant shall submit to the reviewing agency materials necessary to make the application complete, as specified by the reviewing agency in the written notice of incompleteness. No later than 45 calendar days after receiving additional application materials, submitted in response to a notice of incompleteness, the reviewing agency shall notify the applicant in writing whether the application with the additional materials is complete.

(3) The application shall not be deemed complete if a reviewing agency fails to make a written completeness determination within 45 calendar days. An application is deemed complete when the reviewing agency notifies the applicant in writing that the application is complete.

(4) Nothing in this subsection shall preclude the applicant and any reviewing agency from mutually agreeing to an extension of any time limit specified in this subsection.

(5) After the application is completed, a reviewing agency may request additional information from an applicant, but only when necessary to clarify, modify, or supplement previously submitted material. Requests for such additional information will not render an application incomplete.

(6) If an applicant fails or refuses to correct deficiencies in the application, the application may be denied.

(7) A reviewing agency may conduct a site visit in conjunction with the processing of an application.

(b) No guarantee shall be executed by a corporation until the application has been approved by all reviewing agencies, and the proposed guarantee has been reviewed by the corporation's loan committee and approved by its board of directors, unless the corporation's board of directors has delegated the authority to approve a proposed guarantee to the corporation's loan committee. No guarantee shall be approved or executed by a corporation if the lender is the same entity as the corporation issuing the guarantee.

(c) Upon completion of the review and approval by the corporation's loan committee and/or board of directors, the corporation shall issue a commitment to guarantee and an executed guarantee to the lender.

(d) In the event that a guarantee is issued to a lender without first complying with the requirements of subsections (a) and (b), and the lender relies upon the guarantee in making the loan, the failure by the corporation to so comply shall not constitute a defense on the part of either the agency or the corporation to paying a demand for payment made pursuant to section 5285.

(e) In any case where funds are disbursed to a lender pursuant to a demand and the corporation has failed to comply with subsections (a) and (b), the agency shall immediately exercise all available legal remedies to recover from the corporation the funds disbursed pursuant to the demand.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42101, 42101.3, 42102.4 and 42103, Public Resources Code.

HISTORY

1. New section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

§ 5284. Guarantee Terms.

(a) Following adoption of a resolution by its board of directors, a corporation shall be authorized to issue a commitment letter specifying the conditions under which it will issue a guarantee to a specified borrower.

(b) The terms and conditions of a guarantee shall be consistent with the resolution of the corporation approving the guarantee and shall include all of the following:

(1) Provision that the corporation promises to pay up to ninety percent (90%) of the principal and interest, subject only to the following restrictions:

(A) The lender has complied with all material conditions contained in the guarantee, including perfecting collateral; and,

(B) The lender has not engaged, and will not engage, in fraudulent or grossly negligent practices in connection with the borrower, guarantee, the loan, or the loan agreement.

(2) A statement that the lender shall send to the corporation executing the guarantee, a copy of all delinquency notices mailed to the borrower.

(3) A description of the procedures and the responsibilities of the lender and corporation subsequent to default.

(4) The demand procedures described in section 5285.

(5) Agreement to abide by binding arbitration by the American Arbitration Association in the event that either the corporation or the agency denies the requested demand pursuant to section 5285(d)(2) or (e)(2), or the amount paid to the lender is less than the amount contained in the demand letter.

(6) Acknowledgment by the lender that in the event of a demand, the lender will allow a representative of the California Department of Financial Institutions, or other auditor selected by the corporation and approved by the agency, to examine the lender's loan files.

(7) A designation as to whether the guarantee is a collection guarantee or a loan guarantee.

(8) A statement that the maximum amount of interest to be paid is ninety (90) calendar days at guaranteed percentage. The ninety (90) calendar day limit can only be exceeded with the written approval of the corporation.

(c) The duration of a guarantee on a loan shall not exceed seven (7) years.

(d) The maximum guarantee for any one applicant shall not exceed $100,000.

(e) The corporation shall be authorized to charge a loan guarantee fee not to exceed two (2) percent of the principal amount guaranteed.

(f) For a guarantee with a term greater than one year, the corporation may charge a guarantee servicing fee not to exceed .5% of the principal amount guaranteed. The servicing fee shall be authorized to commence on the first anniversary of the effective date of the guarantee, and to continue annually until the guarantee is released.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42101, 42101.2 and 42102.4, Public Resources Code.

HISTORY

1. New section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

§ 5285. Demand Procedures.

(a) The lender shall be authorized to make a demand upon the corporation executing the guarantee for repayment of the unpaid loan principal and interest pursuant to the terms of the guarantee, upon compliance with the following:

(1) Providing proof to the corporation that the borrower is in default and lender has delivered to both the borrower and the corporation a minimum of two letters subsequent to the delinquency, at least thirty (30) days apart, explaining the consequences for failure to remedy the delinquency. *This requirement shall not* apply if borrower is in bankruptcy.

(2) If the guarantee is a collection guarantee, providing proof that the lender has complied with the liquidation requirements of section 5286.

(b) The lender shall deliver to the corporation executing the guarantee a demand letter requesting immediate payment of the guaranteed portion of loan interest and principal, and documenting compliance with subsection (a).

(c) Within five (5) days of receipt of the demand letter, the corporation shall contract with the California Department of Financial Institutions or an independent auditor to conduct an investigation to determine whether the lender has complied with the terms of the guarantee, and to issue a report to both the corporation and the agency. The investigation shall address each of the following issues:

(1) Whether the loan agreement between the borrower and lender is consistent with the terms and conditions in the guarantee.

(2) Whether all collateral for the loan and guarantee been perfected and maintained. Whether all collateral available for assignment to the corporation in the event that payment is made upon the demand. Whether any collateral is not available as a result of lender's negligence, breach of contract, foreclosure or other cause, and a description of any such collateral.

(3) If the guarantee is a collection guarantee, whether the lender complied with the liquidation procedures of section 5286.

(4) Calculation on the outstanding principal and interest owed.

(5) Whether the lender complied with the procedures for making a demand under section 5285(b).

(6) In a section entitled "Loan Information" the report shall include the following information obtained solely from a review of lender files: a description of the borrower's business, a description of the collateral for the loan, and a discussion as to whether the lender files contain any reference to matters material to borrower's compliance with any environmental laws or regulations. The description of collateral shall identify all real property collateral as one or more of the following: industrial, commercial, agricultural, single family residence, multi–unit residential, vacant lot, or unknown.

(7) A loan history.

(d) Within five (5) days of receiving the California Department of Financial Institutions or auditor's report, the corporation shall do one of the following:

(1) Deliver to the agency a request for payment on the demand, along with: A copy of the report described in subsection (c); the demand; and a calculation of the amount owed pursuant to the guarantee; or,

(2) Deliver to the lender, with a copy simultaneously delivered to the agency, a refusal to make payment pursuant to the demand, and detailing the reasons for refusal.

(e) Within ten (10) calendar days from the date the agency receives the request for payment, the agency shall do one of the following and simultaneously inform the lender of such action:

(1) Deliver or cause to be delivered to the corporation a check in an amount not to exceed the amount contained in the demand letter, made payable to the lender; or,

(2) Deliver or cause to be delivered a denial of the request for payment to the corporation based upon fraud or gross negligence on the part of the lender known to the agency.

(3) Deliver or cause to be delivered to the corporation a statement that the investigation was incomplete, and requiring the corporation to complete the investigation and resubmit the request for payment to the agency within five (5) calendar days from the date the statement is received by the corporation.

(f) The amount paid to the lender pursuant to a demand letter shall be less than the amount contained in the demand letter only under the following circumstances:

(1) The demand contains an incorrect calculation of the amount owing;

(2) The amount owing on the loan has been reduced by subsequent payments from the borrower to the lender; or

(3) The lender has engaged in fraudulent activities pertaining to the loan.

(g) Within one working day of receiving the check from the agency, the corporation shall contact the lender and arrange to deliver the check

to the lender. The corporation shall deliver the check and simultaneously collect an assignment by the lender of the lender's interest in the loan. The assignment shall include the loan note and all collateral, except as provided in section 5286.

(h) Demand must be made upon the corporation no later than noon on the thirty–first calendar day following the date on which the guarantee terminates; provided, however, that if the thirty–first day is not a day upon which the corporation is open for business, the last day for making a demand shall occur on the next succeeding day upon which the corporation is open for business.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42101 and 42102.4, Public Resources Code.

HISTORY

1. New section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

§ 5286. Collection Requirements for Collection Guarantees.

(a) A lender shall not be authorized to file a demand for a collection guarantee unless it has complied with this section. The requirements contained in this section are in addition to the requirements contained in section 5285.

(b) The lender must liquidate all collateral, but shall not be required to file a lawsuit against any borrower or guarantor. "Liquidate" as used in this paragraph means that the lender has exhausted all collateral by one of the following methods:

(1) Converted the collateral into cash;

(2) Demonstrated, to the satisfaction of the corporation that the collateral is without sufficient value to convert to cash; or

(3) Demonstrated that the borrower has filed for bankruptcy.

NOTE: Authority cited: Section 42106, Public Resources Code. Reference: Sections 42101 and 42102.4, Public Resources Code.

HISTORY

1. New section filed 7–26–2006 as an emergency; operative 7–26–2006 (Register 2006, No. 30). This regulatory action is deemed an emergency, was filed directly with the Secretary of State, and shall remain in effect until revised or repealed by the Business, Transportation and Housing Agency pursuant to Public Resources Code section 42106.

* * *

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 7.5. Department of Commerce: Employment and Economic Incentive Act and Enterprise Zone Act

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Chapter 7.5. Department of Commerce: Employment and Economic Incentive Act and Enterprise Zone Act

NOTE: Authority cited: Section 7085(c), Government Code. Reference: Sections 7080, 7081, 7082, 7083, 7084, 7085, 7087 and 7087.5, Government Code.

HISTORY

1. New Chapter 7.5 (Articles 1 and 2, Sections 5200–5243) filed 1–8–85 as an emergency effective upon filing (Register 85, No. 2) A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–8–85.
2. New Articles 3 and 4 (Sections 5600–5636) filed 1–8–85 as an emergency effective upon filing (Register 85, No. 2). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5–8–85.
3. New Articles 1 and 2 (Sections 5200–5243), and new Articles 3 and 4 (Sections 5600–5636) refiled 4–22–85 as an emergency effective upon filing (Register 85, No. 17). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 10–21–85.
4. Editorial correction of HISTORY NOTE No. 3 (Register 85, No. 28).
5. Repealer and new Articles 1 and 2 (Sections 5200–5243), and repealer and new Articles 3 and 4 (Sections 5600–5636) filed 10–9–85 as an emergency effective upon filing (Register 85, No. 42). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed on 4–7–86.
6. Chapter 7.5 (Articles 1–2, Sections 5200–5243 and Articles 3–4, Sections 5600–5636) repealed by operation of Government Code Section 11346.1(g) (Register 87, No.2).

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Chapter 7.6. Trade and Commerce Agency: Rural Economic Development Infrastructure Program

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Chapter 7.6. Trade and Commerce Agency: Rural Economic Development Infrastructure Program

Article 1. Definitions

§ 5300. Definitions.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.1, 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New chapter 7.6 (articles 1–3, sections 5300–5343, not consecutive) filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Editorial correction of printing error amending subsection (a) and newly designated subsections (n)(1) and (o), and adding new subsections (e) and (g) and subsection relettering filed 7–10–89 (Register 93, No. 20).
3. Change without regulatory effect amending chapter heading filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
4. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
6. Amendment of subsection (f), new subsections (i)–(i)(2), (*l*) and (u)–(u)(2), subsection relettering, and amendment of newly designated subsections (o), (q) and (v) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
7. Change without regulatory effect amending subsection (*l*) filed 7–6–98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 28).
8. Certificate of Compliance as to 6–1–98 order, including further amendment of subsection (v), transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
9. Change without regulatory effect repealing chapter (articles 1–4, sections 5300–5353), article 1 (section 5300) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

Article 2. Application Process

§ 5310. Preliminary Review of Eligibility.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Change without regulatory effect amending opening paragraph and subsection (a) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment of section and NOTE filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Amendment of first paragraph and subsection (c), and new subsection (c)(4) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
7. Change without regulatory effect repealing article 2 (sections 5310–5330) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5311. Eligible Projects; Costs.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Amendment filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5312. Community Need.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.6, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Repealer filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5313. Private Development Requirements.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.6, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Editorial correction of printing error adding new first paragraph, designation of subsection (a) and subsection renumbering, and adding new subsections (b)–(b)(6) filed 7–10–89 (Register 93, No. 20).
3. Amendment of section heading and text filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5314. Job Creation or Retention.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.6 and 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment of subsection (a) filed 7–10–89; operative 8–9–89 (Register 89, No. 28).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5315. Relocation.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.6 and 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5316. Private Development Information Requested in the Application.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Section 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment of section heading and text filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Amendment of section heading filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
6. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5317. Need for Panel Funding.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.2(f), 15373.8 and 15373.9(b), Government Code.

HISTORY

1. Repealer of former section 5317 and renumbering and amendment of former section 5319 to section 5317 filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 94, No. 6.
2. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
3. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5318. Funding of Non–Priority Projects.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. Repealer and new section filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 93, No. 20.
2. Certificate of Compliance as to 9–28–94 order including new designator (a) transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
3. Amendment of subsection (b) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5319. Enterprise Fund Loan, Lease, and Tax Increment Loan Agreements.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Section 15373.8, Government Code.

HISTORY

1. Renumbering of former section 5319 to section 5317 and new section filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 87, No. 41.
2. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
3. Amendment of section heading and subsections (a) and (b), and new subsections (c)–(c)(3) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 6–1–98 order, including further amendment of section heading, transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5320. Agency Preliminary Review.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Change without regulatory effect amending section heading and text filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5321. Contents of Notice of Preliminary Review.

NOTE: Authority cited: Section 15373.7(b), Government Code. References: Sections 15373.7 and 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Amendment filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5322. Application Content.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Change without regulatory effect amending subsection (a) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order including amendment of subsection (b)(1) transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Amendment of subsections (a) and (b)(15)(C) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5323. Source of Loan Repayments.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5324. Commitment by Private Sector Firm.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9(d), Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 7–10–89; operative 8–9–89 (Register 89, No. 28).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Amendment of subsection (a) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5325. Borrower Site Control.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9(e), Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5326. Borrower Administrative Capacity.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9(f), Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5327. General Plan.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9(g), Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5328. CEQA Compliance.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Section 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Change without regulatory effect amending subsection (b) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5329. Agency Review of Applications.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Change without regulatory effect amending section heading and text filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order including amendment of section transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5330. Panel Action on Applications.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Section 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Repealer of subsection (a) designation, amendment of text, and repealer of subsections (b)–(b)(2) filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
4. Amendment filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–1–98 order transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
6. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

Article 3. Funding

§ 5340. Loan Terms.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7 and 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment filed 7–10–89; operative 8–9–89 (Register 89, No. 28).
3. Amendment of section heading and repealer and new text filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).
5. Amendment of subsections (c) and (e) filed 6–1–98 as an emergency; operative 6–1–98 (Register 98, No. 23). Pursuant to Government Code section 15373.07, a Certificate of Compliance must be transmitted to OAL by 11–30–98 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 6–1–98 order, including further amendment of subsection (e), transmitted to OAL 11–25–98 and filed 1–12–99 (Register 99, No. 3).
7. Change without regulatory effect repealing article 3 (section 5340) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 5341. Special Loan Terms.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7 and 15373.8, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment of subsection (b) filed 7–10–89; operative 8–9–89 (Register 89, No. 28).
3. Repealer filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).

§ 5342. Grants.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Amendment of subsection (a) filed 7–10–89; operative 8–9–89 (Register 89, No. 28).
3. Repealer filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).

§ 5343. Reports.

NOTE: Authority cited: Section 15373.7(b), Government Code. Reference: Sections 15373.7, 15373.8 and 15373.9, Government Code.

HISTORY

1. New section filed 10–1–87; operative 10–7–87 pursuant to Government Code section 11346.2(d) (Register 87, No. 41).
2. Repealer filed 9–28–94 as an emergency; operative 9–28–94 (Register 94, No. 39). A Certificate of Compliance must be transmitted to OAL by 1–26–95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 9–28–94 order transmitted to OAL 12–16–94 and filed 1–31–95 (Register 95, No. 5).

Article 4. Disaster Grant Assistance

HISTORY

1. Repealer of article 4 (sections 5350–5353) by operation of Government Code section 11346.1(g) filed 1–22–91 (Register 91, No. 19).

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 7.65. Trade and Commerce Agency: Tourism Marketing Act

Vol. 14

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Chapter 7.65. Trade and Commerce Agency: Tourism Marketing Act

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Chapter 7.65. Tourism Marketing Act

Subchapter 1. Definitions

§ 5350. Definitions.

(a) "Accommodation Location" is any passenger car rental location on the property of a hotel, motel or other accommodation facility.

(b) "Act" means the California Tourism Marketing Act, Government Code Section 13995 *et seq.*

(c) "Airport Location" is any passenger car rental location on an airport property or servicing an airport and subject to either an airport concession agreement or an airport access fee agreement.

(d) "Assessed Business" means a Business which derives any California Gross Receipts from a California Business Location from one or more Industry Segments and participates in the Tourism Assessment Program by paying an annual Assessment pursuant to the Act.

(e) "Assessment" means the amount of Business Location annual fees owed by the Assessed Business to the Office pursuant to the Act.

(f) "Assessment Rate" for the Passenger Rental Car Industry Segment shall be calculated by taking (i) the funding required for the Commission under the Act ($25,000,000 for fiscal year 2006–2007; $50,000,000 for fiscal year 2007–2008 and thereafter) less (ii) the Estimated Amount for such fiscal year, and dividing this result by (iii) the estimated Revenue for the entire Passenger Car Rental Industry segment for such fiscal year as determined under Section 5357.1 below. For all other segments, the "Assessment Rate" shall be as determined by referendum under the Act.

(g) "Authorized Representative" means a person authorized by the Business to sign and provide the information required in the Registration Form and the Ballot. Examples of authorized representatives include sole proprietor, corporate officers, general partners and fiduciaries.

(h) "Ballot" means the written document sent to Assessed Businesses consisting of the information listed in Section 5355.

(i) "Business" means an individual (sole proprietorship), partnership, fiduciary, corporation, association, or any other business organization, whether operating on a profit or nonprofit basis.

(j) "Business Location" means the California street address where Travel and Tourism Revenues are generated by a Business. If the Business has more than one business license for a single address, then each activity requiring a business license is a separate Business Location.

(k) California Travel and Tourism Commission ("CTTC") is the commission that promotes California as a tourism destination, both domestically and internationally. It is headquartered at 980 9th Street, Suite 480, Sacramento, CA 95814.

(*l*) "California Gross Receipts" means gross receipts minus returns and allowances from sales in California. Examples of California Gross Receipts are the amount shown on line 1c of Schedule F, Form 100 of the California Franchise Tax Board, 1996 revision date, line 3 on Schedule C, Form 1040 of the Internal Revenue Service, 1996 revision date, or for multi–state operations, column (b) on line 3, "total sales" of schedule R–1 of the California Franchise Tax Board, 1996 revision date.

(m) "Commissioner" means a member of the board of commissioners of the California Travel and Tourism Commission, established pursuant to Government Code Section 13995.40.

(n) "Estimated Amount" means for a given fiscal year the sum of the amount estimated by the Office to be (i) payable as Assessments by all Assessed Businesses other than the Passenger Car Rental Industry Segment and (ii) contributed by the State of California general funding.

(o) "Exempt Business" means a Business meeting one or both of the following requirements:

(1) The Business is an Exempt Travel Agent/Tour Operator; and/or

(2) The Business is a Public Body.

(p) "Exempt Business Location" means a Business Location meeting one or more of the following:

(1) The Business Location derives less than one percent (1%) of its California Gross Receipts from Travel and Tourism Revenue within Industry Segment(s);

(2) The Business Location derives California Gross Receipts from any of the following Industry Segments within the attractions and recreation Industry Category where the business does not charge an admission fee or gate: museums and art galleries, arts or science center, historical society, planetarium, botanical and zoological gardens, aquarium, animal and reptile exhibit and arboretum;

(3) The Business Location derives Revenue from any Industry Segment(s) in the restaurants and retail Industry Category, where the business activity meets one or more of the following definitions:

(A) Contract feeders serving hospitals, schools, prisons, employee cafeterias and/or restaurants;

(B) Catering vendor trucks serving job sites and other employment locations; and/or

(C) Restaurants on university campuses and military bases; and/or

(4) The Business Location has California Gross Receipts under one million dollars ($1,000,000) for the accounting period listed in the Business' most recent income tax return. If the accounting period is less than twelve (12) months, California Gross Receipts shall be annualized using the formula described in section 5353(g).

(q) "Exempt Revenues" means:

(1) Within the attractions and recreation Industry Category, California Gross Revenue from rentals of the following for more than thirty (30) days: canoes, houseboats, pleasure boats, rowboats, sailboats, surfing equipment and spaces in marine basins and/or yacht basins.

(2) Within the travel and transportation Industry Category, California Gross Revenue from interstate transportation and/or sales of diesel fuel.

(3) Within the travel and transportation Industry Category, California Gross Revenue from regular route intrastate and interstate bus service; provided, however that Exempt Revenues shall not include California Gross Revenue derived from bus service which is of a type that requires authority (whether in the form of a certificate of public convenience and necessity or a permit) to operate as a charter–party carrier of passengers pursuant to Chapter 8 (commencing with Section 5351) of Division 2 of the Public Utilities Code.

(r) "Exempt Travel Agent/Tour Operator" means a Business which meets both of the following requirements:

(1) It derives at least 51% of its California Gross Receipts from one or more of the following Industry Segments: travel agencies and/or tour operator/packager & wholesaler ("Travel Agent"); and

(2) It derives less than twenty percent (20%) of its Travel Agent California Gross Receipts from Travel and Tourism Revenue where the travel occurs within California.

(s) "Industry Category" means the following classifications within the tourism industry:

(1) Accommodations.

(2) Restaurants and retail.

(3) Attractions and recreation.

(4) Transportation and travel services.

(5) Passenger Car Rental Industry.

The definition of each Industry Category is the sum of all Industry Segments contained within that Industry Category. For example, the accommodations Industry Category is the sum of its Industry Segments, including motel, vacation lodges and ski lodges.

(t) "Industry Segment" means those subsets of Industry Categories contained in Section 5352.

(u) "Office" means the Office of Tourism of the State of California, Business, Transportation and Housing Agency that administers the California Travel and Tourism Assessment including processing of all payments. It is also located at 980 9th Street, Suite 480, Sacramento, CA 95814.

(v) "Paid in Full" means the Assessed Business has paid all past and current annual Assessments, late fees and/or penalties due.

(w) "Passenger Car Rental Industry Segment" is defined as those companies renting passenger vehicles at an Airport Location or Accommodation Location in California. Passenger Vehicle is as defined in Section 465 of the California Vehicle Code.

(x) "Public Body" means a public entity or a corporation where a majority of the corporation's board of directors is appointed by a public official or public entity, or serves on the corporation's board of directors by virtue of being elected to public office, or both. As used herein, a "public entity" is an agency, department or instrumentality of the United States, State of California, or any political subdivision thereof. As used herein, a "public official" is an employee of a public body or a person elected to the public body, who serves as a representative of that public body when making the appointment.

(y) "Registration Form" means the form described in Section 5353.

(z) "Referendum" means any vote by mailed ballot of measures recommended by the Commission and approved by the Secretary pursuant to Government Code Section 13995.60 and/or 13995.92.

(aa) "Referendum Request" means the method used by Assessed Businesses to place on a Referendum additional Commissioner candidates and/or a different assessment level pursuant to Government Code Section 13995.62 and section 5354.1 of this chapter except for the initial referendum, which shall consist of measures contained in the selection committee report, discussed in Section 13995.30.

(bb) "Revenue" is all paid time and/or mileage charges only, including upgrades, as shown on each concluded Rental Agreement, net of any discount at California Airport Locations and Accommodation Locations. Revenue shall not include "replacement rentals". A "replacement rental" is defined as any rental which is a temporary replacement of an individual's primary vehicle arising from loss of use due to maintenance, repairs, physical damage, or theft.

(cc) "Secretary" means the Secretary of the Business, Transportation and Housing Agency, or his/her designee.

(dd) "Travel and Tourism Revenue" means California Gross Receipts derived from expenditures to and/or within California by people who (1) travel at least fifty (50) miles from home, one way, for purposes other than commuting to work or school; or (2) have an overnight accommodation as part of the travel, regardless of the distance or purpose traveled. "Home" as used in this definition means the place where the person has resided for the most recent 31 consecutive days.

(ee) "Voluntary Participant" means a Business which participates in the Tourism Assessment Program pursuant to Government Code Sections 13995.49 or 13995.77.

(ff) "Weighted Vote" means a vote equal to the Assessment paid by the Assessed Business; used to determine issues on a Referendum pursuant to Government Code Section 13995.64.

NOTE: Authority cited: Section 13995.69, Government Code. Reference: Sections 13995.20, 13995.40, 13995.49, 13995.60, 13995.64, 13995.65.5, 13995.77 and 13995.92, Government Code.

HISTORY

1. New chapter 7.65 (sections 5350–5354) and section filed 1–29–97 as an emergency; operative 1–29–97 (Register 97, No. 5). A Certificate of Compliance must be transmitted to OAL by 5–29–97 or emergency language will be repealed by operation of law on the following day.
2. Amendment of subsection (k)(2) filed 2–24–97 as an emergency; operative 2–24–97 (Register 97, No. 9). A Certificate of Compliance must be transmitted to OAL by 6–24–97 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 1–29–97 and 2–24–97 orders, including amendment of subsections (g), (k)(4) and (o) and of NOTE, transmitted to OAL 3–26–97 and filed 5–6–97 (Register 97, No. 19).
4. Amendment of subsection (d), new subsections (e) and (i) and subsection relettering filed 7–1–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 27).
5. Change without regulatory effect adding new subsections (k)(5) and (*l*)(3) filed 8–29–97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 35).
6. Amendment of subsection (e) filed 12–8–99 as an emergency; operative 12–8–99 (Register 99, No. 50). A Certificate of Compliance must be transmitted to OAL by 4–6–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section as it existed prior to 12–8–99 emergency amendment by operation of Government Code section 11346.1(f) (Register 2000, No. 25).
8. Amendment of subsection (e) filed 7–17–2000; operative 7–17–2000 pursuant to Government Code section 11343.4(d) (Register 2000, No. 29).
9. Amendment of section and NOTE filed 8–7–2001; operative 9–6–2001 (Register 2001, No. 32).
10. New subchapter 1 heading and amendment of section and NOTE filed 12–29–2006 as an emergency; operative 1–1–2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5–1–2007 or emergency language will be repealed by operation of law on the following day.
11. New subchapter 1 heading and amendment of section and NOTE refiled 4–26–2007 as an emergency; operative 5–2–2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–30–2007 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as 4–26–2007 order, including further amendment of subsections (f), (w) and (z)–(bb), transmitted to OAL 7–2–2007 and filed 8–13–2007 (Register 2007, No. 33).

Subchapter 2. Tourism Assessment Program

§ 5352. Industry Segments.

Below is a complete listing of all Industry Segments, categorized by Industry Category:

(a) ACCOMMODATIONS
Bed and breakfast inn
Campgrounds
Campsite
Casino hotel
Dude ranch
Hotels
Hotel, franchised
Inns
Lodging house, except organization
Lodging house, organization
Motels
Motel, franchised
Motor Inn
Recreational vehicle parks
Resort hotel
Resort hotel, franchised
Seasonal hotel
Ski lodge
Tourist camps, cabins, cottages, and courts
Trailer park
Vacation lodges

(b) RESTAURANTS & RETAIL
American restaurant
Barbecue restaurant
Cajun restaurant
Carry–out only (except pizza) restaurant
Chicken restaurant
Chinese restaurant
Commissary restaurant
Drive–in restaurant
Ethic food restaurants
Family restaurant, chain
Family restaurant, independent
Fast–food restaurant, chain
Fast–food restaurant, independent
Fast–food stand
French restaurant
German restaurant
Greek restaurant
Health food restaurant
Indian/Pakistan restaurant
Italian restaurant
Japanese restaurant

Korean restaurant
Lebanese restaurant
Lunch counter (restaurant)
Mexican restaurant
Pakistani restaurant
Pizza restaurants
Seafood restaurants
Spanish restaurant
Sushi bar
Steak restaurant
Thai restaurant
Vietnamese restaurant
Box lunch stand
Buffet (eating places)
Cafeteria
Cafe
Chili stand
Coffee shop
Concessionaire
Contract food services
Delicatessen (eating places)
Diner
Dinner theater
Eating places
Food bars
Frozen yogurt stand
Grills (eating places)
Hamburger stand
Hot dog stand
Ice cream stands or dairy bars
Luncheonette
Lunchroom
Oyster bar
Pizzeria, chain
Pizzeria, independent
Sandwiches and submarines shop
Seafood shack
Snack bar
Snack shop
Snow cone stand
Soda fountain stand
Soft drink stand
Drinking places
Bar (drinking places)
Bars and lounges
Beer garden (drinking places)
Cocktail lounge
Saloon
Tavern (drinking places)
Wine bar
Night clubs
Cabaret
Discotheque
Art dealers
Athletic shoes
Books
Camera, photo
Children's apparel
Children's shoes
Computer & software
Department stores, discount
Department stores, non–discount
Family apparel
Family shoes
Florists
Gems and precious stones
Gift, novelty; souvenir

Hobby, toys, games
Jewelry
Luggage, leather
Men's shoes
Men's/boys apparel
Misc. apparel
Misc. general merchandise stores
Misc. home furnishings
News stands
Optical
Radio, television, electronics
Record & tape
Specialty sporting goods
Sporting goods
Stationery
Tobacco
Variety stores
Women's apparel
Women's shoes
Women's specialty apparel

(c) ATTRACTIONS AND RECREATION
Aerial tramway or ski lift, amusement or scenic
Air shows
Amusement concession
Amusement parks
Amusement ride
Animal and reptile exhibit, with admission fee
Aquarium, with admission fee
Aquariums and zoological gardens, with admission fee
Arboretum, with admission fee
Art gallery, with admission fee
Art gallery, noncommercial, with admission fee
Arts or science center, with admission fee
Ballet production
Beach and water sports equipment rental and services
Botanical garden, with admission fee
Cave operation
Concession operator
Fair
Festival operation
Fishing boats, party, operation
Fishing lakes and piers, operation
Gambling establishment
Gambling machines, operation
Historical society, with admission fee
Hot air balloon rides
Houseboat rentals, revenue on rental of 30 days or less
Marine basins, revenue on rental of 30 days or less
Museum, with admission fee
Observation tower operation
Opera company
Pack train, for amusement
Performing arts center production
Pier, amusement
Planetarium, with admission fee
Plays, road and stock companies
Pleasure boat rental, revenue on rental of 30 days or less
Recreation equipment rental
Repertory, road or stock companies; theatrical
Rodeo operation
Rowboat and canoe rental, revenue on rental of 30 days or less
Saddlehorse rental
Sailboat rental, revenue on rental of 30 days or less

Scenic railroads for amusement
Ski rental concession
Spas
Sporting goods rental (not elsewhere classified)
Summer theater
Surfing equipment rental, revenue on rental of 30 days or less
Symphony orchestra
Theatrical companies
Theme park, amusement
Tourist attraction, commercial
Tourist attractions, amusement park concessions and rides
Waterslide operation
Wax museum, commercial
Yacht basins, revenue on rental of 30 days or less
Zoological garden, commercial
Zoological garden, noncommercial, with admission fee

(d) TRANSPORTATION AND TRAVEL SERVICES
Airport ground transportation service
Automobile rental, with driver
Charter buses, excursions except interstate, revenue reportable to PUC
Cruise ships/deep sea passenger transport, revenue reportable to PUC
Excursion board operators/inland water local tour
Ferries operating across rivers or within harbors
Filling stations, gasoline (exempt sales of diesel fuel)
Gasoline service stations (exempt sales of diesel fuel)
Inland water taxis/ferries
Intercity highway transport, special service
Interstate bus line, revenue reportable to PUC
Intraport transportation
Limousine rental, with driver
Local bus charter service
Local passenger transportation, not elsewhere classified
Local rental transportation
Marine service station
Motor home rental
Motorcycle rental
Rafting tours
Recreational vehicle rental
Rent-a-car service
Sightseeing boats
Sightseeing bus, revenue reportable to PUC
Taxicabs
Tour and guide services
Tour operators/packagers & wholesalers
Travel agencies
Water taxis

(e) PASSENGER CAR RENTAL INDUSTRY
Passenger car rentals

NOTE: Authority cited: Section 13995.69, Government Code. Reference: Sections 13995.20, 13995.65.5 and 13995.92, Government Code.

HISTORY

1. New section filed 1-29-97 as an emergency; operative 1-29-97 (Register 97, No. 5). A Certificate of Compliance must be transmitted to OAL by 5-29-97 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 1-29-97 order, including amendment of NOTE, transmitted to OAL 3-26-97 and filed 5-6-97 (Register 97, No. 19).
3. New subchapter 2 heading and amendment of section and NOTE filed 12-29-2006 as an emergency; operative 1-1-2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5-1-2007 or emergency language will be repealed by operation of law on the following day.
4. New subchapter 2 heading and amendment of section and NOTE refiled 4-26-2007 as an emergency; operative 5-2-2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-30-2007 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as 4-26-2007 order transmitted to OAL 7-2-2007 and filed 8-13-2007 (Register 2007, No. 33).

§ 5353. Registration Form.

The Registration Form, entitled "California Tourism Marketing Act: Registration Form, Form 2650 (rev 4/97)" shall consist of the below listed items. A Business must complete a separate form for each Business Location.

(a) Affix the mailing label in the space provided at the beginning of the Registration Form. If the preprinted label is incorrect or missing, enter the correct information as follows:

(1) Business Location name;

(2) Address; and

(3) City, state and zip code.

(b) Enter the federal employer identification number ("FEN") of the Business. If the Business does not have an FEN, it is mandatory to list the social security number of the primary owner. The social security number is required pursuant to the Act and will be used as an identifier for the Business.

(c)(1) Go to the listing of section 5352 Industry Segments contained in the package containing the Registration Form. Identify the Industry Segment from which the Business Location earns the greatest portion of its California Gross Receipts. List the alphabetical code of the Industry Category in which the Industry Segment is listed, or list "E:exempt" as described in subsection (c)(2). For example, the hotel Industry Segment is listed in the accommodations Industry Category: "A." The Industry Categories shall be listed as follows:

A: accommodations;

B: restaurants and retail;

C: attractions and recreation; and

D: transportation and travel services.

(2) Select "E:exempt," if the Business Location derives no California Gross Receipts from any Industry Segment, is a Public Body or is an Exempt Business Location pursuant to subsection 5350(i)(3) and/or (4), and describe the principal activity of this Business (or reason why this is a Public Body or Exempt Business Location).

(3) If the Business listed "E: exempt," skip to the signature line described in subsection (n). Otherwise, the Business shall proceed with the next line in the Registration Form.

(d) Answer the question: is this Business a travel agency, tour operator, packager or wholesaler that derives less than twenty percent (20%) of its California Gross Revenue from Travel and Tourism Revenue where the travel occurs within California. If the answer is yes, the Business is an Exempt Business. Skip to the signature line described in subsection (n). Otherwise, the Business shall proceed with the next line in the Registration Form.

(e) If the Business wishes to pay a flat rate assessment of $250,000 for this Business Location, which is the maximum assessment amount, complete that number in the assigned space and skip to the signature line described in subsection (n). Otherwise, the Business shall proceed with the next line in the Registration Form.

(f) Enter the ending month and the year of the accounting period for the Business' most recent income tax return. For example, for the calendar year 1996, enter 12/96.

(g) Enter the California Gross Receipts of this Business Location for the period listed in subsection (f). If the income tax return for the period shown in subsection (f) is less than twelve months, annualize the revenue by multiplying the revenue by the number twelve (12) and dividing the result by the number of months on the short period. Thus, a business with $1,000,000 in California Gross Receipts for six months would multiply that number by 12 and divide by 6, giving an annualized California Gross Receipts of $2,000,000. If this amount is less than $111,000, you are an Exempt Business Location. Skip to the signature line described in subsection (n).

(h) From the amount listed in subsection (g), subtract Exempt Revenues and any California Gross Receipts not derived from Industry Segments and enter the balance.

(i) Enter the estimated percentage of the subsection (h) figure that is Travel and Tourism Revenue. For example, 25% would be written as .25, 8% as .08. The percentage of Travel and Tourism shall be estimated for the year ending on the date specified in subsection (f). If the Initial Referendum passes, assessments will be based upon documented surveys or other methods of determining the Travel and Tourism percentage. If the number listed is less than .08, this is an Exempt Business Location. Skip to the signature line described in subsection (n). Otherwise, the Business shall proceed with the next line in the Registration Form.

(j) Multiply the number written in answer to the subsection (h) question by the number written in answer to the subsection (i) question. Enter the resulting number. For example, $1,000,000 times 0.65=$650,000.

(k) Multiply the number listed in subsection (j) by .00045 and enter the resulting number, rounded to the nearest dollar. If the amount is less than fifty dollars ($50), this is an Exempt Business Location. Skip to the signature line described in subsection (n). If the answer to line 10 is equal to or greater than $50, than proceed with the next line in the Registration Form.

(*l*) List the name, title and phone number of the Authorized Representative to whom the Office shall mail the Referendum.

(m) If the Referendum ballot should be mailed to a different address or name than that pre-printed on the Registration Form, check the provided box and list the corrected Business name, address, and city, state, zip code.

(n) The portion of the Registration Form requiring a signature commences with the following: "Under penalty of perjury, I declare that I have examined the above information and to the best of my knowledge and belief, it is true, correct and complete." This section of the Registration Form shall be completed listing the name and title of the Authorized Representative, and shall include the signature and date of signature of the Authorized Representative.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15372.66, 15372.86, 15372.118 and 15372.121, Government Code.

HISTORY

1. New section filed 1-29-97 as an emergency; operative 1-29-97 (Register 97, No. 5). A Certificate of Compliance must be transmitted to OAL by 5-29-97 or emergency language will be repealed by operation of law on the following day.
2. Amendment of subsection (d) filed 2-24-97 as an emergency; operative 2-24-97 (Register 97, No. 9). A Certificate of Compliance must be transmitted to OAL by 6-24-97 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 1-29-97 and 2-24-97 orders, including amendment of first paragraph and subsections (c)(1), (c)(2)-(d), (g) and (n) and of NOTE, transmitted to OAL 3-26-97 and filed 5-6-97 (Register 97, No. 19).

Subchapter 3. Referendum Procedures

§ 5354. Referendum Voting Eligibility.

(a) An Assessed Business, including a Voluntary Participant, which is Paid in Full by the date declared by the Secretary pursuant to section 5356(a)(1), is entitled to a Weighted Vote in a Referendum.

(b) An Assessed Business shall vote for Commissioners representing the Industry Category under which the Business Location is classified.

(c) An Exempt Business or an Exempt Business Location, that is not a Voluntary Participant, is not eligible to vote in a Referendum.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15372.66, 15372.79, and 15372.104, Government Code.

HISTORY

1. New section filed 1-29-97 as an emergency; operative 1-29-97 (Register 97, No. 5). A Certificate of Compliance must be transmitted to OAL by 5-29-97 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 1-29-97 order, including amendment of subsection (n) and of NOTE, transmitted to OAL 3-26-97 and filed 5-6-97 (Register 97, No. 19).
3. Amendment of section heading, repealer and new section and amendment of NOTE filed 8-7-2001; operative 9-6-2001 (Register 2001, No. 32).
4. New subchapter 3 heading filed 12-29-2006 as an emergency; operative 1-1-2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5-1-2007 or emergency language will be repealed by operation of law on the following day.
5. New subchapter 3 heading refiled 4-26-2007 as an emergency; operative 5-2-2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-30-2007 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as 4-26-2007 order transmitted to OAL 7-2-2007 and filed 8-13-2007 (Register 2007, No. 33).

§ 5354.1. Referendum Subject Matter.

(a) A Referendum shall contain the following subject matter:

(1) The slate of Commissioner candidates identified by Industry Category,

(2) The proposed assessment level, based on specified assessment formulae,

(3) Yes/No vote for continuation of the Commission and the Tourism Assessment Program.

(b) A Referendum may contain additional subject matter as specified in Government Code Section 15372.102(a) and (b).

(c) The content of the Referendum is determined as follows:

(1) By the Commission in the form of a resolution outlining the subject matter for the Referendum to the Secretary and/or

(2) By Assessed Businesses in the form of a Referendum Request to the Secretary.

(d) An Assessed Business Referendum Request shall be presented to the Secretary by the date announced pursuant to section 5356(a)(2).

(e) An Assessed Business Referendum Request shall include all of the following:

(1) The subject matter requested to be placed on the Referendum:

(A) Additional Commissioner candidates pursuant to Government Code Section 15372.102(c), and/or

(B) Different assessment levels pursuant to Government Code Section 15372.102(b).

(2) A list of each Assessed Business supporting the Referendum Request, and a copy of each Assessed Business's agreement to add candidates for Commissioner or to change the assessment levels. The agreement shall include:

(A) A statement supporting the Referendum Request to add candidates and/or assessment levels to the Referendum, specifying the candidate's names and/or assessment levels,

(B) The Assessed Business name, address, assessment program identification number, Industry Category, and the number of Weighted Votes attributed to the Assessed Business, and

(C) The printed name and title of the Authorized Representative for the Assessed Business.

(f) Upon receipt of the Referendum Request the Secretary shall verify the documentation provided in the Referendum Request to determine whether or not the required Weighted Votes have been presented in support of placing the subject matter of the Referendum Request on the Referendum.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15372.87, 15372.100, 15372.102, 15372.103, 15372.104 and 15372.111, Government Code.

HISTORY

1. New section filed 8-7-2001; operative 9-6-2001 (Register 2001, No. 32).

§ 5355. Ballot and Voting Procedure.

(a) The Ballot for the Referendum shall consist of the following items:

(1) The voting deadline;

(2) The proposed Assessment formula or formulae, the amount of votes the Assessed Business will receive and the total votes from all Assessed Businesses eligible to vote;

(3) The Commissioner candidates from each Industry Category as well as the Industry Category of the Assessed Business;

(4) A space for write-in Commissioner candidate(s);

(5) The following question: "Shall the California Travel and Tourism Commission and the California Tourism Assessment Program continue to operate for the purpose of promoting California as a travel and tourism destination?" (asking the Assessed Business to mark yes or no);

(6) A signature line for the Authorized Representative and a certification that the individual is the Authorized Representative; and

(7) Instructions on where to return the Ballot.

(b) The Assessed Business shall mark the Ballot, sign the Ballot, and return the Ballot by the voting deadline.

(c) A Ballot shall be considered valid if it is postmarked or hand delivered to the Office by the voting deadline, completed as required in subsection 5355(b) and submitted by an eligible Assessed Business.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15372.65, 15372.70, 15372.86, 15372.100 and 15372.104, Government Code.

HISTORY

1. New section filed 7–1–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 27).
2. Change without regulatory effect amending first paragraph filed 9–23–97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 39).
3. Amendment of section heading, section and NOTE filed 8–7–2001; operative 9–6–2001 (Register 2001, No. 32).

§ 5356. Referendum Procedure.

(a) The Secretary shall call a Referendum every two years as required by the Act. The following information shall be announced:

(1) The date Assessed Businesses shall be Paid in Full, thereby ensuring their eligibility to vote in the Referendum.

(2) The dates by which all Commission resolutions and Assessed Business Referendum Requests shall be delivered to the Secretary for inclusion in the Referendum,

(3) The Referendum time periods are determined pursuant to Government Code Section 15372.103.

(b) The Office shall mail the Ballot to all eligible Assessed Businesses as described in section 5354. The number of votes that each Assessed Business receives is determined as described in Government Code Section 15372.104.

(c) For each vacant Commissioner slot within its Industry Category, an Assessed Business shall be authorized to substitute the name of one write–in candidate, as provided in section 5355(a)(4). In the event a write–in candidate and a candidate listed on the section 5355(a)(1) slate of Commissioner candidates receive the same number of votes, the Secretary shall break the tie with a random selection process such as a coin toss. If the total number of write–in candidates exceeds the total number of vacant Commissioner slots within a Business' Industry Category, the Ballot shall be void.

(d) The Secretary shall count and tabulate the valid Ballots and certify the results not later than 30 calendar days from the voting deadline. The certified results shall be sent to all Assessed Businesses that returned valid Ballots.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15372.86, 15372.100, 15372.103, and 15372.104, Government Code.

HISTORY

1. New section filed 7–1–97; operative 7–1–97 pursuant to Government Code section 11343.4(d) (Register 97, No. 27).
2. Amendment of section and NOTE filed 8–7–2001; operative 9–6–2001 (Register 2001, No. 32).

§ 5356.1. Commissioner Referendum Procedure; Commissioner Referendum Ballot.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15372.70, 15372.100, 15372.102, 15372.103 and 15372.104, Government Code.

HISTORY

1. New section filed 12–8–99 as an emergency; operative 12–8–99 (Register 99, No. 50). A Certificate of Compliance must be transmitted to OAL by 4–6–2000 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 25).
3. New section filed 7–17–2000; operative 7–17–2000 pursuant to Government Code section 11343.4(d) (Register 2000, No. 29).
4. Repealer filed 8–7–2001; operative 9–6–2001 (Register 2001, No. 32).

Subchapter 4. Passenger Car Rental Industry Tourism Assessment

§ 5357. Passenger Car Rental Industry Assessment.

(a) The passenger car rental industry tourism assessment collection program shall apply to companies that have business locations renting passenger vehicles at either Airport Location or Accommodation Locations in California.

(b) The Passenger Car Rental Industry Tourism Assessment shall not be subject to the exemption provisions in Government Code section 13995.77.

NOTE: Authority cited: Section 13995.69, Government Code. Reference: Sections 13995.20, 13995.65.5 and 13995.92, Government Code.

HISTORY

1. New subchapter 4 (sections 5357–5358.1) and section filed 12–29–2006 as an emergency; operative 1–1–2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5–1–2007 or emergency language will be repealed by operation of law on the following day.
2. New subchapter 4 (sections 5357–5358.1) and section refiled 4–26–2007 as an emergency; operative 5–2–2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–30–2007 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as 4–26–2007 order, including amendment of subchapter heading and section, transmitted to OAL 7–2–2007 and filed 8–13–2007 (Register 2007, No. 33).

§ 5357.1. Determination of Annual Assessment Rate for Passenger Car Rental Industry Assessment.

(a) The assessment for each business of the Passenger Car Rental Industry Segment shall be the Assessment Rate multiplied by such business' Revenue.

(b) The rate shall be adjusted annually by the Office and such adjustment shall not be subject to annual referendum.

(1) By March 31st of each year, each member of the Passenger Car Rental Industry Segment shall submit to the Office the Revenue data for the previous calendar year.

(2) The Office shall annually determine the percentage of Revenue to be collected from the Passenger Car Rental Industry Segment for the following fiscal year, based on the Revenue data received by the Industry as required in Section (b)(1). If the Office does not receive a complete report of Revenue for a given fiscal year, the Office may estimate the additional Revenue based on prior year's information, extrapolation from reported revenue or any other reasonable method.

(3) The assessment rate will be calculated by dividing the revenue required to be funded by statute for the upcoming fiscal year, by the Revenue reported in the previous calendar year.

(4) The Office shall notify the passenger car rental industry of the applicable assessment rate for the next fiscal year by May 1st of that year.

(5) At the end of each fiscal year, if the amount paid by the Passenger Car Rental Industry Segment provides an excess or deficit in funding, that excess or deficit shall be taken into account in setting the subsequent year's rate as provided for in subsection (b)(3).

NOTE: Authority cited: Section 13995.69, Government Code. Reference: Section 13995.92, Government Code.

HISTORY

1. New section filed 12–29–2006 as an emergency; operative 1–1–2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5–1–2007 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–26–2007 as an emergency; operative 5–2–2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–30–2007 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as 4–26–2007 order transmitted to OAL 7–2–2007 and filed 8–13–2007 (Register 2007, No. 33).

§ 5357.2. Payment of Assessment.

(a) The Passenger Car Rental Industry Segment assessment will be payable monthly, beginning January 2007. All assessments collected by a car rental company for a given month shall be submitted to the Office within 25 days of each month end beginning February 25, 2007.

(b) The Passenger Car Rental Industry Segment Assessment Form, (OT–100, new 1/1/2007) hereby incorporated by reference, shall be submitted by each member of the Passenger Car Rental Industry Segment together with the remittance of the assessment calculated thereon.

(c) A Passenger Car Rental Company shall be assessed a late penalty as set forth in Government Code Section 13995.72 for failure to submit a timely Passenger Car Rental Industry Segment Assessment Form and payment as required by this section.

NOTE: Authority cited: Section 13995.69, Government Code. Reference: Sections 13995.20, 13995.65.5 and 13995.92, Government Code; and Section 2015.5, Code of Civil Procedure.

HISTORY

1. New section filed 12–29–2006 as an emergency; operative 1–1–2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5–1–2007 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–26–2007 as an emergency; operative 5–2–2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–30–2007 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as 4–26–2007 order, including new subsection (c) and amendment of NOTE, transmitted to OAL 7–2–2007 and filed 8–13–2007 (Register 2007, No. 33).

§ 5358. Confidentiality.

(a) All information or data provided by the Passenger Car Rental Industry Segment shall be maintained by the Office and will be confidential. It shall not be released to any person or company, including the CTTC.

NOTE: Authority cited: Section 13995.69, Government Code. Reference: Section 13395.92, Government Code.

HISTORY

1. New section filed 12–29–2006 as an emergency; operative 1–1–2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5–1–2007 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–26–2007 as an emergency; operative 5–2–2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–30–2007 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as 4–26–2007 order transmitted to OAL 7–2–2007 and filed 8–13–2007 (Register 2007, No. 33).

§ 5358.1. Continuation of Passenger Car Rental Industry Assessment.

(a) This Assessment program shall remain in effect, and the Passenger Car Rental Industry Segment shall pay the assessment required, until: (1) Section 1936.01 of the California Civil Code is amended to prohibit or impair the ability of the Passenger Car Rental Industry Segment to separately quote or charge taxes, customer facility charges, airport concession fees, and tourism assessments, or (2) the date the results of the 2013 referendum are announced by the Secretary, unless the assessment is reaffirmed by vote of the Passenger Car Rental Industry Segment conducted in conjunction with the 2013 referendum.

NOTE: Authority cited: Sections 13995.69 and 13995.65.5, Government Code. Reference: Section 13995.92, Government Code.

HISTORY

1. New section filed 12–29–2006 as an emergency; operative 1–1–2007 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 5–1–2007 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4–26–2007 as an emergency; operative 5–2–2007 (Register 2007, No. 17). A Certificate of Compliance must be transmitted to OAL by 8–30–2007 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as 4–26–2007 order transmitted to OAL 7–2–2007 and filed 8–13–2007 (Register 2007, No. 33).

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Title 10. Investment

Chapter 7.66. Technology, Trade and Commerce Agency: Hyperlink Criteria for Central Reservation Services

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Chapter 7.66. Technology, Trade and Commerce Agency: Hyperlink Criteria for Central Reservation Services

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Chapter 7.66. Technology, Trade and Commerce Agency Hyperlink Criteria for Central Reservation Services

§ 5359. Definitions.

The following definitions shall apply to the regulation contained in this chapter, in addition to the definitions contained in section 5350:

(a) Central Reservation Service means a business that maintains a computerized inventory of Lodging Properties that a User can access to reserve overnight accommodations via the internet. A Central Reservation Service shall comply with the requirements described in section 5359.2.

(b) General Central Reservation Service means a Central Reservation Service that meets the benchmarks described in section 5359.3.

(c) IATA Number means the International Association of Travel Agents number that is used to identify a particular Travel Agent or tour operator for billing purposes and the payment of commissions.

(d) Lodging Properties means any place of business that provides overnight accommodations for a fee, including but not limited to: hotels; motels; bed and breakfast inns; spas; dude ranches; golf resorts; youth hostels; farm stay; campgrounds; recreational vehicle parks; and rental properties such as condominiums, cabins, houses, and apartments.

(e) Proposal means a request, submitted by a Central Reservation Service, for the establishment of a hyperlink on the Tourism Web Site. Proposals shall include the information described in section 5359.5.

(f) Real Time Reservations means a computerized service offered by Lodging Properties that allows Users to use the internet to make, confirm, and modify reservations for overnight accommodations. Users of Real Time Reservations shall not be required to contact a Lodging Property by telephone, mail, facsimile, or any means other than the internet to obtain information about the availability or rate of accommodations. Lodging Properties with Real Time Reservations shall set aside an inventory of guest rooms for Users.

(g) Specialty Central Reservation Service means a Central Reservation Service that meets the following requirements:

(1) It complies with the benchmarks described in section 5359.4

(2) It has an inventory dedicated to one (1) category of Lodging Property that is patronized by consumers seeking a unique experience or service that is not typically associated with a national hotel or motel chain. For example, the inventory of a Central Reservation Service might be dedicated to bed and breakfast inns, spas, dude ranches, or golf resorts.

(h) Tourism–Marketing Regions means the twelve (12) geographic areas described on the Tourism Web Site under the subheading "Regions": http://gocalif.ca.gov/regions. The names of the Tourism Marketing Regions are as follows:

(1) The Central Coast.
(2) The Central Valley.
(3) The Deserts.
(4) The Gold Country.
(5) The High Sierra.
(6) The Inland Empire.
(7) Los Angeles County.
(8) The North Coast.
(9) Orange County.
(10) San Diego County.
(11) The San Francisco Bay Area.
(12) The Shasta Cascade.

(i) Tourism Web Site means the web site maintained by the Office: http://gocalif.ca.gov.

(j) User means any person or entity that accesses the Tourism Web Site to obtain information about travel destinations located in California or to make reservations at a Lodging Property located in California.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New chapter 7.66 (sections 5359–5359.7) and section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.1. Proposal Process.

(a) The Office shall be authorized to maintain up to nine (9) hyperlinks with Central Reservation Services on the Tourism Website. Three (3) of the hyperlinks shall be reserved for General Central Reservation Services and six (6) of the hyperlinks shall be reserved for Specialty Central Reservation Services. A summary of the requirements for the establishment of a hyperlink shall be posted on the Tourism Web Site. The Web Site will contain a disclaimer that indicates that the Reservation Services linked to the site are privately operated and not connected with or endorsed by the State of California.

(b) The Office shall accept Proposals from Central Reservation Services for the establishment of hyperlinks on a continuous basis. A Central Reservation Service applying for a hyperlink shall submit one (1) original and one (1) copy of the Proposal described in section 5359.5 to the Office. All Proposals received by the Office shall be kept on file until a hyperlink becomes available.

(c) When a hyperlink becomes available, the Office shall conduct a technical review of each Proposal on file to determine whether or not it is complete. The Office shall mail a notice to each Central Reservation Service that submitted an incomplete Proposal identifying the steps that must be taken to correct the deficiencies contained in the Proposal, within thirty (30) days of the date the hyperlink became available. A Central Reservation Service shall have a period of fourteen (14) days from the date of mailing of the notice to correct the deficiencies. If the deficiencies are not corrected within the fourteen (14) day period, the Proposal shall be disqualified from further consideration.

(d) No later than thirty (30) days following the subsection (c) technical review, a panel consisting of not less than two (2) and not more than four (4) professional employees of the Agency shall use the criteria described in section 5359.5 to score all Proposals that meet the eligibility requirements described in section 5359.2. The Office shall award a hyperlink to the Central Reservation Service(s) that receives the highest score, until all available hyperlinks have been awarded. The Office shall mail a notice to each Central Reservation Service that submitted an eligible Proposal indicating whether the Proposal was approved or disapproved within ninety (90) days of the date the hyperlink became available. The Office shall retain all disapproved, eligible Proposals for future consideration. If only one (1) Proposal for an available hyperlink is received, the Office shall award the hyperlink to the Central Reservation Service that submitted that Proposal, so long as the Central Reservation Service meets the requirements described in section 5359.2. If no eligible Proposals are received, the hyperlink shall remain unfilled until the Office receives an eligible Proposal.

(e) Not later than fourteen (14) days following the mailing of a notice approving a Proposal, a Central Reservation Service shall establish a hyperlink on the Tourism Web Site. If the hyperlink is not established within the fourteen (14) day period, the Office shall award the hyperlink to another Central Reservation Service pursuant to the procedures described in subsection (d). A hyperlink shall expire three (3) years following the date of establishment, except for hyperlinks currently posted on the Tourism Web Site which shall expire three (3) years following the effective date of this regulation.

(f) Thirty (30) days after being disqualified pursuant to subsection (c) or having its hyperlink expire pursuant to subsection (e), a Central Reservation Service shall be eligible to submit another Proposal to the Office.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.2. Eligibility Requirements for Central Reservation Services.

A Central Reservation Service shall be eligible to establish and maintain a hyperlink on the Tourism Web Site when the Office has determined that all of the requirements listed below have been satisfied.

(a) Information provided by the Central Reservation Service pertains exclusively to Lodging Properties and travel or consumer services located inside of the state of California.

(b) The Central Reservation Service displays photographs or graphics depicting at least seventy–five percent (75%) of the Lodging Properties included in its inventory.

(c) The Central Reservation Service uses a random method of displaying Lodging Properties that meet a User's search request.

(d) The Central Reservation Service provides a User support component. The telephone number of the User support component, including area code, shall be displayed on the Central Reservation Service's web site. Live operators shall be available to respond to User's queries about reservation confirmations, reservation modifications, commissions, overbooking, rate disputes, and other types of consumer problems between the hours of 0900 and 2100 Monday through Friday, and 1000 and 1800 Saturday through Sunday (Pacific Standard Time).

(e) The Central Reservation Service includes a statement on its web site explaining how a Lodging Property can apply for inclusion in its inventory. A Central Reservation Service shall not deny participation to a Lodging Property solely because of the Lodging Property's membership in or affiliation with a travel industry organization.

(f) The Central Reservation Service maintains a security policy that includes a secure method for transactions, including credit card encryption.

(g) The Central Reservation Service complies with the requirements described in section 5359.6 and sections 5359.3 and 5359.4, as appropriate.

(h) The Central Reservation Service identifies Lodging Properties that pay commissions to Travel Agents and tour operators and provides a means for processing IATA Numbers over the internet.

(i) Neither the Central Reservation Service nor any of the Lodging Properties listed in the Central Reservations Service's inventory shall have any financial arrangement with the Agency whereby the Central Reservation Service or Lodging Property makes a payment to or receives a payment from the Agency in connection with the use of the hyperlink.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.3. Lodging Property Benchmarks for General Central Reservation Services.

(a) Upon the execution of an agreement to establish a hyperlink on the Tourism Web Site, a General Central Reservation Service shall include:

(1) Not less than three hundred (300) Lodging Properties that have the capacity to provide Real Time Reservations.

(2) Not less than (10) Lodging Properties in each of the twelve (12) Tourism Marketing Regions.

(b) No later than twelve (12) months after establishing a hyperlink on the Tourism Web Site, a General Central Reservation Service shall include:

(1) Not less than five hundred (500) Lodging Properties that have the capacity to provide Real Time Reservations.

(2) Not less than twenty (20) Lodging Properties in each of the twelve (12) Tourism Marketing Regions.

(c) Not later than eighteen (18) months after establishing a hyperlink on the Tourism Web Site, a General Central Reservation Service shall include not less than one thousand (1,000) Lodging Properties, with an aggregate total of not less than fifty thousand (50,000) individual guest rooms, that have the capacity to provide Real Time Reservations.

(d) A General Central Reservation Service shall maintain the benchmarks described in subsections (c) and (b)(2) until the hyperlink expires pursuant to section 5359.1(e).

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.4. Lodging Property Benchmarks for Specialty Central Reservation Services.

(a) Upon the execution of an agreement to establish a hyperlink on the Tourism Web Site, a Specialty Central Reservation Service shall include:

(1) Not less than fifty percent (50%) of the Lodging Properties that exist in the category to which the Specialty Central Reservation Service is dedicated. For example, if a Specialty Central Reservation Service is dedicated to dude ranches and there are one hundred fifty (150) dude ranches in the state of California, it shall be required to include at least seventy–five (75) dude ranches. If less than one hundred (100) Lodging Properties exist in a category, a Specialty Reservation Service shall include at least seventy–five (75%) of the Lodging Properties in that category. For example, if there are ninety (90) health spas in the state of California, a Specialty Reservation Service dedicated to health spas shall be required to include at least sixty–eight (68) health spas.

(2) Not less than one (1) Lodging Property from each of the twelve (12) Tourism Marketing Regions, unless a particular category of Lodging Property does not exist in a Tourism Marketing Region.

(b) A Specialty Central Reservation Service shall maintain the benchmarks described in subsection (a) until the hyperlink expires pursuant to section 5359.1(e).

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.5. Proposal Content and Scoring Criteria.

Proposals submitted by Central Reservation Services shall contain the information described in subsections (a) through (j).

(a) The name, address, telephone number, e–mail address, and when available, facsimile number of the Central Reservation Service.

(b) The name and title of the Central Reservation Service's Authorized Representative.

(c) The name and title of the Central Reservation Service's contact person, if different than subsection (b)

(d) A description of the Lodging Properties to be included in the Central Reservation Service's inventory at the time that the hyperlink is established. This description shall include the number of Lodging Properties that have the capacity to provide Real Time Reservations, the number of Lodging Properties located in each of the Tourism Marketing Regions, and the number of Lodging Properties that will be depicted graphically or in photographs. A Specialty Central Reservation Service shall also describe the category of Lodging Property to which its inventory shall be dedicated, the number of Lodging Properties that exist in that category statewide, and documentation that indicates how that number was determined. (0 to 15 points)

(e) A description of the method the Central Reservation Service shall use to display Lodging Properties that meet a User's request. (0 to 10 points)

(f) A description of the Central Reservation Service's User support component. This description shall include the number of live operators available to respond to User's queries and the hours the operators will be on duty. This description shall also identify any subcontractor(s) that will provide User support, including the subcontractor's name, address and telephone number, and a brief description of the subcontractor's experience in User support. (0 to 15 points)

(g) A description of the application process used by the Central Reservation Service when selecting Lodging Properties for inclusion in its inventory. (0 to 5 points)

(h) A description of the measures the Central Reservation Service shall take to prevent the pilferage of credit card numbers and other personal information submitted by Users. (0 to 10 points)

(i) A description of the features the Central Reservation Service shall include on its web site to assist Travel Agents in identifying and booking commissionable Lodging Properties. (0 to 10 points)

(j) A description of the Central Reservation Service's experience in providing consumer and travel related services (0 to 10).

(k) A certification signed and dated by the Central Reservation Service's Authorized Representative. The certification shall include the following language: I hereby certify, under penalty of perjury under the laws of the State of California, that the information provided in this report is true and correct and that I will inform the California Trade and Commerce Agency, Office of Tourism immediately of any changes therein.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15354.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.6. Usage and Reporting Requirements.

(a) On the seventh (7th) day of each month, all Central Reservation Services shall submit a usage report to the Office. The usage report shall contain the information described in subsections (a)(1) through (a)(9).

(1) The name, address, and e–mail address of the Central Reservation Service.

(2) The name and telephone of the Central Reservation Service's contact person.

(3) The number of new and the number of continuing Users that have accessed the Central Reservation Service during the prior month.

(4) The number of Users that have used the Central Reservation Service to make reservations at Lodging Properties during the prior month, the average number of nights those Users stayed at Lodging Properties, and the average nightly rate per stay.

(5) The number of Users that have used the Central Reservation Service to make Real Time Reservations at Lodging Properties during the prior month.

(6) The number of Users that have used the Central Reservation Service to cancel reservations at Lodging Properties during the prior month.

(7) The number of commissions earned by the Travel Agents and/or Tour Operators who booked reservations on the Central Reservation Service during the prior month.

(8) The number of Lodging Properties included in the Central Reservation Service's inventory and the Tourism Marketing Regions in which those properties are located. A General Central Reservation Services shall also provide the number of Lodging Properties in its inventory that have the capacity to provide Real Time Reservations and the aggregate number of guest rooms contained in its inventory.

(9) A certification signed and dated by the Central Reservation Service's Authorized Representative. The certification shall include the following language: I hereby certify, under penalty of perjury under the laws of the State of California, that the information provided in this report is true and correct and that I will inform the California Technology, Trade and Commerce Agency, Office of Tourism immediately of any changes therein.

(b) No later than March 1st of each year, the Office shall prepare and distribute an annual usage report to each Central Reservation Service that has a hyperlink on the Tourism Web Site. In the annual usage report, the Office shall compile and summarize the information collected pursuant to subsection (a), including the aggregate number of reservations made by Users on General Central Reservation Services and the aggregate number of reservations made by Users on Specialty Central Reservation Services.

(c) Any General Central Reservation Service that fails to attain at least fifteen percent (15%) of the total reservations made by Users of General Central Reservation Services, and any Specialty Central Reservation Service that fails to attain at least ten percent (10%) of the total reservations made by Users of Specialty Central Reservation Services shall be subject to the provisions set forth in section 5359.7.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

§ 5359.7. Termination of Hyperlink

(a) The Office shall provide written notice to a Central Reservation Service that fails to comply with one or more of the requirements described in sections 5359.2, 5359.3, 5359.4, or 5359.6. The notice shall describe the requirements the Central Reservation Service has failed to comply with and shall include a deadline for the correction of the deficiencies. A Central Reservation Service shall have fourteen (14) days to comply with the requirements and to notify the Office that the deficiencies have been corrected.

(b) If a Central Reservation Service does not comply with the requirements described in sections 5359.2, 5359.3, 5359.4, or 5359.6 and provide notice to the Office by the deadline described in subsection (a), the Office shall terminate the Central Reservation Service's hyperlink to the Tourism Web Site.

(c) Not later than fourteen (14) days following the termination of a hyperlink, a Central Reservation Service may submit a written response appealing the termination. The response shall describe each fact contained in the subsection (a) notice that the Central Reservation Service disputes and any information that the Central Reservation Service believes to mitigate or explain the facts upon which the notice based.

(d) Not later than fourteen (14) days following the receipt of the subsection (c) response, the Office shall issue a written decision. The decision shall include findings of fact and conclusions demonstrating one of the following:

(1) The termination of the hyperlink is appropriate.

(2) The termination of the hyperlink is not appropriate. If this finding is made the Office shall reinstate the Central Reservation Service's hyperlink within fourteen (14) days.

NOTE: Authority cited: Section 11152, Government Code. Reference: Sections 15364.51(f) and 15364.53, Government Code.

HISTORY

1. New section filed 7–20–2001; operative 8–19–2001 (Register 2001, No. 29).

* * *

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CALIFORNIA CODE OF REGULATIONS

Title 10. Investment

Chapter 7.67. California Welcome Centers

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Chapter 7.67. California Welcome Centers

§ 5370. Definitions.

The following definitions shall apply to the regulations contained in this chapter:

(a) "Agency" means the Business, Transportation and Housing Agency.

(b) "California Welcome Center" means a visitor information center, designated by the State which is accessible to and recognizable by tourists and which encourages tourism in California.

(c) "Center" means the property proposed as a California Welcome Center.

(d) "Office" means the Office of Tourism, also known as the Division of Tourism, within the Business, Transportation and Housing Agency.

(e) "Major Holiday" means New Year's Day, Easter Sunday, Thanksgiving, and Christmas.

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Sections 13995.150 and 13995.151, Government Code.

HISTORY

1. New chapter 7.67 (sections 5370–5377) and section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5371. Eligiblity.

(a) To be eligible for designation as a California Welcome Center, an applicant shall meet the following requirements:

(1) The applicant shall be a convention center, visitor bureau, chamber of commerce, local government, state government, federal government, private entity or combination of the above.

(2) The applicant shall have a permanent structure with heating and air conditioning at the proposed property site and adequate public parking facilities, including buses and recreational vehicles.

(3) The property shall be within two (2) miles of a major interstate freeway or highway.

(4) The applicant shall have authority to permanently display the required signage on the exterior of the proposed property site. Applicant shall also have authority to display signage on local/city streets leading from the highway to the Center.

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Sections 13995.150, 13995.152 and 13995.153, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5372. Application Process.

(a) The Office shall provide a Solicitation of an open application period for a California Welcome Center to all interested persons and shall post it on the Office website. The Solicitation shall be for a designated area(s), based on the necessity for a new or replacement Center. The Solicitation shall include a description of the Application process and the Application deadline. The Application deadline shall be no earlier than thirty (30) calendar days following the mailing of the Solicitation.

(b) Not later than the deadline described in the subsection (a), each Applicant shall submit an original and four (4) copies of a completed Application to the Office.

(c) Not later than sixty (60) calendar days following the deadline described in subsection (a), the Agency shall mail to each Applicant that submitted an Application either a notice disapproving the request or a letter of conditional designation. The letter of conditional designation shall indicate that the final designation is conditioned upon execution of an agreement between the Applicant and the Agency.

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Sections 13995.150 and 13995.151, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5373. Application. General Information.

The General Information Section of the application shall contain the following information:

(a) Applicant Information

(1) The Applicant's name, address, county, telephone and facsimile numbers, e–mail address (if applicable).

(2) Operating entity of the proposed center, i.e. Chamber of Commerce, City, County, etc.

(3) The name and title of the Applicant's Director or Manager and address and telephone and facsimile number, if different than subsection (a)(1).

(b) A non–refundable application fee of $1,000.

(c) Proposal plans as specified in Section 5374.

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Section 13995.151, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5374. Proposal Plans and Scoring Criteria.

(a) Proposal shall contain the following information and shall be scored on the criteria listed under each section.

(1) Site Plan. (0 to 20 points)

(A) The physical address of the proposed Center.

(B) Size and location of property. Include a description of the proximity to tourist attractions, restaurants and lodging and distance from major freeways or highways.

(C) Central heating and air conditioning capacity.

(D) The architectural theme of the facility and how it is representative of local surroundings.

(E) Restroom facilities and Americans with Disabilities Act (ADA) compliance.

(F) An interior display space to include the following: Lay out for information racks, service desk and rest rooms. The lay out must include plans that allow, at a minimum, eight 2' x 3' display racks, or 25' of linear wall space, or 51 square feet of open space dedicated to brochure display racks, and space for a 42" plasma screen.

(G) Direct Internet access, preferably with speed of 128kb or better, for visitor use.

(H) Parking facilities, including RV and bus parking.

(2) Marketing Plan. (0 to 20 points) The marketing plan shall include the following:

(A) Public Relations.

1. Describe any public relations efforts that will promote the proposed center.

(B) Direct Sales

1. A list of any merchandise to be sold at the center, the benefit the merchandise has to the traveler and the competitive pricing of the merchandise with other local vendors.

2. A list of any and all commercial establishments attached to the proposed property and the level of service it will provide to the traveler.

3. A list of any travel services provided at the center, including travel arrangements, ticket booking service and internet service.

4. A commitment that the California Welcome Center shall not provide any real estate or time–shares sales, or engage in or support telemarketing.

5. Describe any other plans to promote the center through direct sales.

(C) Print Advertising

1. Describe any plans to promote the Center through print advertising.

(3) Financial Plan. (0 to 20 points) The financial plan shall describe or include the following:

(A) Funding sources and financial ability to meet hours of operation, on–going marketing activities and payment of the annual $5,000 fee.

(4) Operational Plan. (0 to 30 points) The operational plan shall include the following:

(A) Description of proposed staffing which shall include a manager with decision–making authority. Include number of full–time and part–

time staff, and indicate paid or volunteer. Describe proposed uniforms or name tags that will distinguish the staff from the visitors.

(B) Commitment to operate seven days a week, except for major holidays.

(C) Describe in detail the plan to gather, display and maintain visitor brochures and travel-related information from throughout the State.

(D) Building Maintenance. Provide plans for maintaining the building, restrooms and grounds surrounding the center.

(E) Proof of insurance on the proposed property. The Applicant shall furnish to the Office a certificate of insurance stating that there is comprehensive general liability insurance in effect for the property with a combined single limit of not less than one million dollars per occurrence for bodily injury and property liability combined.

(F) Office Equipment.

(G) Operating hours and how they meet the needs of travelers in that area.

(H) Training Plans for Staff.

(I) Authorization by the property owner that the applicant can display signage for a California Welcome Center on the exterior of the proposed property and evidence that signage will be in compliance with any relevant city or county ordinances or applicable conditions, covenants and restrictions.

(J) Provide the method used for tracking the number of visitors to the Center.

(K) Description of visitor traffic patterns including current and projected visitor numbers and determination of whether a center is warranted in said area. If another California Welcome Center is located within 50 miles of the proposed location, description of how the visitor traffic patterns will support both centers.

(5) Local or Community Support (0 to 10 points)

(A) A letter from at least two of the following: the community's principal destination marketing organization, tourism association, city or county, supporting the establishment of a California Welcome Center in the area.

(b) Eligible Proposals receiving between eighty-five (85) and one hundred (100) points shall be considered for designation and a site visitation shall be scheduled.

(c) Site visitation. (0–20 Points) A site visitation of the proposed Center will be conducted to verify the site and operational plan and to evaluate the Applicants understanding of the role of a California Welcome Center.

(d) The Agency shall award the designation to the Applicant(s) receiving the highest score.

(e) The designation shall be for a five-year period, with the first year being a probationary period. At the end of the five years, the Center shall submit in writing a letter of intent to continue operation of the Center and the Office shall re-evaluate the effectiveness and appropriateness of continuing a Center designation at the same location.

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Sections 13995.150, 13999.151, 13995.152, 13995.153 and 13995.154, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5375. Continuing Responsibility of CWC.

(a) Upon designation as a California Welcome Center, the Center shall be required to comply with the following:

(1) An annual maintenance fee of $5,000 shall be paid to the Office on a fiscal year basis. This payment shall be due either in a lump sum of $5,000 due July 1, or quarterly payments of $1,250 each due July 1, October 1, January 1 and April 1.

(2) The Center shall pay for all fees associated with required signage, including permits, construction and placement of signs.

(3) The Center shall report to the Office the number of visitors for each month, by the sixth of the following month.

(4) The Center shall request approval from the Office in order to use the Traveling Bear logo, the "California Welcome Center" or the Find Yourself Here logo on any merchandise, uniforms or signage. The Center shall submit the request to the Office.

(5) All merchandise sold in the Center shall be appropriate for all ages of travelers.

(6) The Center shall provide on-going training to their personnel including current visitor information on new attractions, events, destinations and accommodations in their region and throughout the State.

(7) The Center shall display all local (city and county in which the center is located), state and federal governmental tourism information at no cost to the governmental agency. The Center may charge other organizations for the costs of displaying and providing visitor information, including graphic displays and brochures.

(8) The operating entities of each center shall promote the California Tourism Website (www.visitcalifornia.com) and the California Welcome Center Website (www.visitcwc.com) in advertising, in promotional activities, in related collateral, on the physical premises, and on their website.

(9) The Center's manager or a designated representative with decision-making authority shall attend a minimum of three manager's meetings each year. The Office shall establish the meeting dates and places and will provide the managers the opportunity to share current visitor information including new attractions, events, destinations and accommodation in their region.

(10) The Center shall be required to pass periodic site inspections by Office staff. The site inspections shall not occur more frequently than once a year. The site inspection will verify that the Center is continually meeting the site specifications in the original proposal.

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Sections 13995.150, 13999.151, 13995.152 and 13995.153, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5376. Revocation of Designation.

(a) Failure to comply with the provisions in Section 5375, shall be cause for revocation of the California Welcome Center's designation.

(1) The Office shall provide written notice to a California Welcome Center that fails to comply with one or more the requirements in Section 5375. The notice shall describe the deficiencies and shall include a deadline for correction of the deficiencies.

(2) If the California Welcome Center fails to correct the deficiencies as required in subsection (a)(1), the designation shall be revoked. The revocation shall be effective 30 days after the deadline specified in subsection (a)(1).

NOTE: Authority cited: Section 13995.151, Government Code. Reference: Sections 13995.150, 13995.151, 13995.152 and 13995.153, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

§ 5377. Appeal Process.

(a) Appeal of the revocation shall be in writing and shall include the following:

(1) Name and address of California Welcome Center making the appeal.

(2) Statement of the basis of the appeal.

(3) Documentation which supports the position of the California Welcome Center, submitted under the penalty of perjury.

(b) An appeal by a California Welcome Center shall be served on the Office within 30 days of the effective date of the revocation.

(c) The Office shall respond in writing to the appeal by the California Welcome Center within 30 days.

(d) The California Welcome Center can appeal the Office's decision to the Agency Secretary by submitting a copy of the original complaint and the Office's written decision within 30 days of the date of the Office's decision.

(e) The Secretary shall respond in writing within 30 days of receipt of the California Welcome Center's appeal and submission.

NOTE: Authority cited: Sections 13995.151 and 13995.155, Government Code. Reference: Sections 13995.150, 13995.151, 13995.152 and 13995.153, Government Code.

HISTORY

1. New section filed 8–1–2006; operative 8–31–2006 (Register 2006, No. 31).

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Title 10. Investment

Chapter 7.7. Trade and Commerce Agency: Competitive Technology Program

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Chapter 7.7. Department of Commerce: Competitive Technology Program

Article 1. Definitions

§ 5400. Definitions.

The following terms shall have the meanings set forth below:

(a) "Act" means Chapter 3.5 (commencing with Section 15379) of Part 6.7 of Division 3 of Title 2 of the California Government Code.

(b) "Affiliate", as to a specified person, means a person that directly, or through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. A person controls another person within the meaning of this definition through the possession, direct or indirect, of the power to direct or cause the direction of the management, policies or actions of such other person.

(c) "Agency" means the Trade and Commerce Agency.

(d) "Allowable overhead costs" means indirect costs or overhead calculated in conformity with the principals and procedures set forth in (1) the United States Federal Register, Vol. 53, No. 199, Part V, Office of Management and Budget, Circular No. A-87, Friday, October 14, 1988, or (2) the United States Federal Register, Volume 44, No. 45, Office of Management and Budget, Circular No. A-21, March 6, 1979, each as amended from time to time, or any successor thereto, incorporated by reference herein and available from the department.

(e) "Applicant" means a public agency, or a not-for-profit or a nonprofit organization, which applies for a grant.

(f) "Application" means the application for a grant submitted and filed pursuant to Article 2.

(g) "California-based foundation" means a nonprofit organization which complies with all of the following:

(1) it is a private foundation as defined in Title 26, Section 509 of the United States Codes;

(2) it is incorporated in California; and

(3) it receives at least 51% of its funding from California companies.

(h) "California company" means a private firm which does not qualify as a nonprofit organization, which either:

(1) has at least 100 employees in California, or

(2) the average of the property factor, the payroll factor and the sales factor (as defined in Section 25129, 25132 and 25134 of the California Revenue and Taxation Code, incorporated by reference herein) with respect to such company exceeds 50% during the latest full income year, so that the weighted average of such company's property, sales and employment exceeds 50% in California.

(i) "Collaborative research" means new or ongoing technological or scientific research that accelerates existing research towards the commercialization of product(s), process(es) or service(s), and is conducted jointly or funded jointly by some or all of the following:

(1) Private sector, including intra-industry groups, California-based private foundations, industry associations, and nonprofit cooperative associations..

(2) The federal government.

(3) The state.

(4) Public or private universities, colleges, and laboratories.

(j) "Committee" means the Competitive Technology Advisory Committee created pursuant to Government Code Section 15333.6.

(k) "Consortium" means a non-profit organization jointly funded and/or jointly operated by two or more funding sources, which is an independent research and development organization. As used in this subsection, "independent research and development organization" means an organization that performs technology transfer directly or by contracting with other entities to perform all or part of this function.

(l) "Consortium development" means a project to organize and establish a consortium to fund and manage technology transfer with respect to a specific technology or industry and which meets the requirements of Sections 5413(a)(7) & (8) and 5450.

(m) "Consortium project" means a project which is one of the following:

(1) consortium development;

(2) consortium technology transfer;

(3) a combination of (1) and (2).

(n) "Consortium technology transfer" means a project to fund and manage technology transfer with respect to a specific technology or industry priority where the applicant is either:

(1) a consortium previously established by a consortium development project; or

(2) a California nonprofit corporation previously established by all consortium funding sources for the purpose of funding technology transfer. As used in this subsection, "California nonprofit corporation" means a corporation organized and in good standing as a nonprofit corporation under Title 1, Division 2 of the California Corporations Code.

(o) "Cooperative research" means a new collaborative research project.

(p) "Discretionary grant" means a grant awarded in accordance with the provisions of Section 5431.

(q) "Entrepreneurial business development" means a project which is intended to result in either (1) product(s), process(es) or service(s) made available for commercialization by small businesses, or (2) a procedure implemented by the applicant to assist commercialization of product(s), process(es) and service(s) by small businesses.

(r) "Funding phase" means the nature and duration of a project as described in Section 5424.

(s) "Grant" means funding for a project provided under the Act in the form of payment[s] to an applicant pursuant to a grant agreement.

(t) "Grant agreement" means any agreement entered into between the agency and an applicant that is approved for funding by the secretary to provide a grant for a project on such terms and conditions as shall be required by the agency and agreed to by the applicant.

(u) "Industry association" means either:

(1) a nonprofit organization or a nonprofit association (as defined in Part 2 (commencing at Section 21000) of Title 3 of the Corporations Code) whose membership and funding includes a California company; or

(2) any advisory board, committee, council or commission operating pursuant to either Chapter 1 (commencing at Section 58601) of Part 2 of Division 21 of the Food and Agriculture Code or Division 22 (commencing at Section 64001) of the Food and Agriculture Code.

(v) "Industry member" means an entity other than a nonprofit organization or a public entity which is participating in the funding and/or management of a consortium project.

(w) "In-kind contribution" means the value of personnel and equipment provided by any entity other than the agency and meeting the requirements of Section 5412(d) and (e).

(x) "Matching contribution" means a contribution to the cost of a project made by a private sector participant pursuant to Section 5412.

(y) "Multiyear grant" means a grant consisting of funds encumbered from more than one year, subject to the requirements of Sections 5430.

(z) "Nonprofit cooperative association" means an association organized and operating pursuant to either Chapter 1 (commencing with Section 54001) of Division 20 of the Food and Agriculture Code or Part 2 (commencing with Section 12200) of Division 3 of Title 1 of the Corporations Code.

(aa) "Nonprofit organization" means a corporation organized and in good standing as a nonprofit corporation under Title 1, Division 2 of the California Corporations Code or the equivalent nonprofit corporation law of any other state, or any organization which has received a determi-

nation letter to that effect from the Internal Revenue Service under Section 501(c) of the Internal Revenue Code of 1986.

(bb) "Person" means an individual, a corporation, a partnership, a joint venture, an association, a joint stock company, a trust, or an unincorporated organization.

(cc) "Private sector participant" means a company that makes a matching contribution that meets the requirements of Section 5416.

(dd) "Program" means the California Competitive Technology Program created pursuant to the Act.

(ee) "Program area" means one of the following categories which describe the purpose of a project:

(1) cooperative research;

(2) consortium development;

(3) consortium technology transfer;

(4) entrepreneurial business development;

(5) technology transfer innovation; or

(6) unsolicited proposal.

(ff) "Program priority" means a category of technology or industry that receives priority for funding pursuant to Section 5423.

(gg) "Project" means an endeavor designed to achieve technology transfer, including access to ongoing research and research findings, exchange or transfer of personnel, research support services including capital outlay, and collaborative research.

(hh) "Public agency" means an agency, agency or instrumentality of the federal government, any state, or any political subdivision of a state.

(ii) "Research institution" means a public or independent university, college or laboratory.

(jj) "Secretary" means the secretary of the Agency.

(kk) "Small business" means a United States domiciled concern as defined in Section 2 of Public Law 85–536 (15 U.S.C. 632) and implementing regulations specified in 13 C.F.R. Section 121.2, as amended from time to time, or any successor thereto, incorporated by reference herein.

(*ll*) "Sub–project" means a third–party project which is solicited, evaluated, funded and administered by a consortium technology transfer project.

(mm) "Sub–solicitation" means the application instructions used to solicit third–party projects developed and utilized by an applicant awarded a grant in a consortium project. The requirements for a sub–solicitation are described in Article 5.

(nn) "Technology transfer" means the movement of the results of basic or applied technological or scientific research to the design, development, and production of new or improved product(s), service(s), or process(es).

(oo) "Technology transfer innovation" means a project to develop a new system or procedure by the applicant to assist California companies with technology transfer.

(pp) "Unsolicited proposal" means an application for a project which is not described by any of the categories defined in Section 5400(ee)(1)–(5) of the definition of program area.

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5, 15333.6, 15379.1, 15379.3, 15379.4, 15379.5, 15379.6, 15379.7 and 15379.10, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Amendment filed 9–8–92 as an emergency; operative 9–8–92 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
3. Amendment refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–4–93 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–8–93 order transmitted to OAL with amendments 9–2–93 and filed 10–18–93 (Register 93, No. 43).
5. Editorial correction amending HISTORY 2 and 3 (Register 93, No. 43).
6. New subsections (c) and (*ll*), repealer of subsections (o) and (p), subsection redesignation and amendment of subsections (w) and (jj) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
7. Amendment of subsection (q), repealer of subsections (y)–(z)(3) and (ss)–(ss)(3), subsection renumbering, amendment of newly designated subsection (pp), and amendment of NOTE filed 9–18–95; operative 10–18–95 (Register 95, No. 38).

Article 2. Application Process

§ 5410. Contents of Application.

(a) The application shall consist of a cover sheet, a certification page, a budget, a table of contents and attachments as set forth in subsection (f) below. Each attachment shall begin on a separate sheet of paper with the item number and title at the top of the page.

(b) The cover sheet of the application shall be signed and dated by both an authorized representative of the applicant and the project manager, and shall identify or designate the following:

(1) the applicant;

(2) the name, address and phone number of the applicant's authorized representative and project manager;

(3) the project title;

(4) the requested grant amount;

(5) sources of project funds;

(6) the funding phase, program area and technology area for which the application is submitted;

(7) cost sharing as defined in Section 5421;

(8) the county where the project is located; and

(9) whether confidential information is included in the application.

(c) The budget shall contain the information required in Section 5414(a).

(d) The certification page shall contain a certification by an authorized representative of the applicant that the application meets the requirements set forth in Sections 5411(b), 5412(f), 5414(b), 5415, and 5416. The applicant shall also certify that its authorized representative has read these regulations.

(e) The applicant shall prepare and submit a table of contents page which lists each of the items required in the application, and the page number where it is located.

(f) The application shall contain attachments, as appropriate, which include all of the following information:

(1) A summary of the proposed project of not more than 400 words, including an abstract, a statement of the problem or opportunity being addressed by the project, any innovations being pursued, new or improved product(s), process(es) or service(s), that it is anticipated will be commercialized as a result of the project, and a project plan.

(2) The agreement required by Section 5413.

(3) A project narrative containing information the applicant believes necessary for the peer review to be carried out pursuant to Section 5427 and for a review of program goals pursuant to Section 5425(d)(2). The narrative shall include discussions of each of the following in the order set forth herein: objectives, plans, implementation, timetables and milestones for implementation of plans, and criteria for a successful project and evaluation of the project. In addition, an application for a consortium development project shall discuss: (1) processes for determining short and long term research agendas; (2) processes for responding quickly to innovative commercialization ideas and research directives; and (3) a marketing plan for both attracting members and project funding ideas.

(4) Identification of the project manager and key personnel for carrying out the project, including information as to eduction, experience and publications of such personnel relevant to the project.

(5) Discussion of the nature and extent to which the project meets each of the program goals set forth in Sections 5417, 5418, 5419, 5420 and 5422.

(g) Applicants shall submit one (1) signed and clearly identified original and ten (10) copies of the application in a single package to the address specified in the application. The agency shall acknowledge in writing receipt of an application within 21 days of receipt by the agency.

(h) Each application shall consist of white 8 1/2" x 11" paper, printed on one side only, consecutively numbered at the bottom center of the page (including the cover sheet, certifications, budget, and table of contents). Typing or printing on pages prepared by the applicant shall be single through double spaced, in no smaller than 10–pitch or 12–point type. The pages shall be stapled in the upper left–hand corner or contained in a looseleaf binder. All confidential material shall be segregated on separate pages stamped "Confidential" at top and bottom. Material designated confidential by the applicant shall be cross–referenced to that part of the application to which it relates. The completed application shall not exceed the following: Phase 0 applications—30 pages; Phase I applications—60 pages, Phase II applications and discretionary grants other than Phase 0—no limit.

(i) Where a description or analysis includes quantified or specialized information, the source of the information and the method of computation or analysis must be described. Any supporting information must be included in the application.

(j) An applicant shall be authorized to withdraw an application at any time by written request to the Agency.

(k) An application for consortium development must meet the requirements of Section 5450.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3, 15379.4, 15379.5, 15329.6 and 15379.7, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Amendment of subsection (k) filed 9–8–92 as an emergency; operative 9–8–92 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
3. Amendment of subsection (k) refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–4–93 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–8–93 order transmitted to OAL with amendment of subsection (f)(3) 9–2–93 and filed 10–18–93 (Register 93, No. 43).
5. Editorial correction amending HISTORY 2 and 3 (Register 93, No. 43).
6. Change without regulatory effect amending subsections (g) and (j) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5411. Projects Generally.

(a) Grant funding shall only be available for expenses incurred, including allowable overhead costs, in connection with a project that receives matching contributions from one or more private sector participants. Grant funds shall not be used to reimburse any costs incurred pursuant to any contract or subcontract for services with respect to a for–profit entity.

(b) The application shall indicate that no less than 90% of project activities will be performed in California, with the following exceptions: (1) work necessary to comply with federal subcontracting statutes, regulations or policies, and (2) performance of a necessary test or procedure where the facilities for such a test or procedure are not available in California.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15379.3, 15379.4 and 15379.6, Government Code.

HISTORY

1. Repealer by operation of Government Code Section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.

§ 5412. Matching Contribution.

(a) The application shall include a commitment letter, letter of intent or other similar evidence that the private sector participant[s] will make a matching contribution[s] to the costs of the project. The application shall also indicate the amount, time and manner in which the matching contribution[s] will be made. The requirements set forth in this subsection shall be met by inclusion of such evidence in the agreement submitted pursuant to Section 5413.

(b) The amount of grant funds compared to the amount of matching contributions shall not be more than the following ratio:

(1) Phase 0 or other discretionary grants—no matching contribution required;

(2) Phase I—2:1; and

(3) Phase II—1:1.

(4) In the case of consortium projects, matching contributions may be from both private sector participants and public agencies or associations of public agencies, provided that, for Phase I or Phase II, the ratio of grant funds to matching contributions is no greater than 1:1 and that the private sector participant match constitutes at least 51% of the total required matching contribution. All entities making matching contributions must comply with the requirements of subsection (a).

(c) Matching contributions shall be in the form of either cash or in–kind contributions of personnel and equipment that will be spent or used after the filing of the application and prior to the end of the term of the grant. If the matching contribution for any project is proposed to be wholly or partly in–kind, the application shall specify the personnel and equipment that comprise the contribution, and shall give the estimated value thereof, consistent with the principles contained in subsections (d) and (e) of this section.

(d) In–kind contributions of personnel shall be valued based upon the salary of such personnel, plus benefits. In–kind contributions of personnel shall only comprise personnel that will directly benefit, and can be specifically identified with, the project.

(e) In–kind contribution of equipment shall meet the following criteria:

(1) The total contribution of equipment must be no more than 20% of the matching contribution;

(2) Contributed equipment must be an integral part of the project; and

(3) The matching funds for equipment contributions shall be valued as follows:

(A) For equipment contributions with a market value of less than $50,000, the matching value will be 50% of the market value;

(B) For equipment contributions with a market value of between $50,000 and $150,000, the matching value will be $25,000 plus 30% of the amount in excess of $50,000; and

(C) For equipment contributions with a market value above $150,000, the matching value will be $55,000 plus 20% of the amount in excess of $150,000.

For purposes of this subsection, equipment shall be considered to be contributed only when the applicant receives title to and possession of the equipment free of charge.

(f) The applicant shall certify that all in–kind contributions meet the criteria set forth in subsections (d) and (e) of this section.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.4, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–9; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. New subsection (b)(4) filed 9–8–92 as an emergency; operative 9–8–92 pursuant to Government Code section 15379.9 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
3. New subsection (b)(4) refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–4–93 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–8–93 order transmitted to OAL 9–2–93 and filed 10–18–93 (Register 93, No. 43).
5. Editorial correction amending HISTORY 2 and 3 (Register 93, No. 43).

§ 5413. Agreement Among Participants.

(a) Each applicant shall at the time the application is submitted include as part of the application an agreement or agreements (in a form specified in subsection (b) below) among all parties proposing to participate in the project (including, where applicable, the applicant, the private sector participant[s], all funding sources, and any other persons or organizations

which are necessary to the project, except the department), which agreement[s] shall address the following:

(1) organization and control of the project;

(2) delineation of the respective roles and responsibilities of all the parties, indicating that all participants, from both the public and private sectors have a direct and ongoing involvement in the project;

(3) identification of the amount, timing and means by which funds and in-kind contributions will be made available to the project by the various participants, as applicable;

(4) financial reporting, including the timing of such reports;

(5) the resolution of any intellectual property rights relative to the project;

(6) consent for any individual participants employed by other than the applicant or private sector participant to participate in the project;

(7) in the case of cooperative research projects or consortium projects, description of how the technology agenda, as defined in Section 5450(b), task selection, dissemination of technology agenda, implementation or commercialization of projects and review processes will be accomplished;

(8) in the case of consortium development projects, a description of the working relationships among the institutions comprising the consortium; an agreement to establish and become members of a California nonprofit corporation, for the purpose of furthering technology transfer, within five years of submitting the application; and

(9) any other matters that the participants deem necessary to be included in such agreement.

(b) The agreement shall be signed by the parties thereto and submitted with the application, or shall be in the form of, or shall be a draft agreement accompanied by, a memorandum of understanding, letter of intent or similar document signed by the applicant participants that evidences the agreement of the parties to perform the project substantially in the manner and on the terms outlined in the application, and committing the parties to execute a final agreement prior to any disbursement of grant funds.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.4, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Amendment of subsections (a)(7)–(8) filed 9–8–92 as an emergency; operative 9–8–92 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
3. Amendment of subsections (a)(7)–(8) refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–4–93 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–8–93 order transmitted to OAL 9–2–93 and filed 10–18–93 (Register 93, No. 43).
5. Editorial correction amending HISTORY 2 and 3 (Register 93, No. 43).

§ 5414. Project Budget.

The application shall include the following:

(a) A proposed budget for the project, including identification of all sources and uses of funds and the estimated value of all in-kind contributions associated with the project. The proposed budget shall include a beginning and an ending date. The budget shall not begin before the date the application is submitted to the department. The budget ending date shall be the projected termination date of the grant agreement. Budget information shall be provided in at least the following categories: personnel, contract services, travel, space and equipment, other costs and allowable overhead costs.

(b) A certification that any overhead costs of a research institution included in the project budget do not exceed that institution's allowable overhead costs.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3, 15379.4, 15379.5 and 15379.6, Government Code.

HISTORY

1. Repealer by operation of Government Code Section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.

§ 5415. Supplanting Other Funding.

The application shall contain a certification that receipt of a grant under the program will not supplant any other funding source for any applicant research institution.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.4, Government Code.

HISTORY

1. Repealer by operation of Government Code Section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.

§ 5416. Private Sector Participants.

The application shall include a certification that each private sector participant, together with its affiliates, if any, complies with either (a) or (b) below:

(a) it is a California company; or

(b) the private sector participant is:

(1) a California–based foundation;

(2) an industry association; or

(3) a nonprofit cooperative association.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.4, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Amendment filed 9–8–92 as an emergency; operative 9–8–92 pursuant to Government Code section 15379.9 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
3. Amendment refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–4–93 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–8–93 order transmitted to OAL 9–2–93 and filed 10–18–93 (Register 93, No. 43).
5. Editorial correction amending HISTORY 2 and 3 (Register 93, No. 43).

§ 5417. Likelihood of Commercialization.

(a) The application shall discuss the likelihood that successful completion of the project will lead to commercialization of product[s], service[s] or process[es] more rabidly than would otherwise occur.

(b) The application shall include a proposed schedule and plan for using the results of the project to develop the product[s], service[s] or process[es]. The plan shall identify, where applicable, necessary intermediate steps, such as completion of other scientific or technical research or development work, the obtaining of additional capital, and the obtaining of additional licenses or patents.

(c) Projects indicating the ability to produce commercial results with fewer uncertainties or intermediate steps shall be deemed more likely to further the program goal in subsection (a) above, in connection with the agency staff review pursuant to Section 5425(d)(1) and (2).

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.4, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5418. Impact on State Economy.

(a) The application shall discuss the positive impacts on California's economy if the project is successfully completed.

(b) The application shall estimate, within annual time frames extending no longer than 10 years from the expected completion of the project, how commercialization of the specified product[s], service[s] or pro-

cess[es] would result in one or more of the following benefits to California's economy:

(1) creation of new jobs (direct and indirect);

(2) retention of jobs at existing industries;

(3) increased sales;

(4) utilization of raw materials from or products manufactured in California;

(5) new construction of facilities and equipment;

(6) increased productivity within an industry or sector of California's economy;

(7) increased exports; or

(8) other positive impacts on California's economy.

(c) Projects indicating greater impact on California's economy within the shortest period of time shall be deemed more likely to further the program goal in subsection (a) above, in connection with the agency staff review pursuant to Section 5425(d)(1) and (2).

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5419. Cost Effectiveness.

(a) The application shall discuss the factors that make the project cost effective.

(b) Projects indicating greater impact on California's economy for the lowest requested grant shall be deemed more likely to further the program goal in subsection (a) above, in connection with the agency staff review pursuant to Section 5425(d)(1) and (2).

NOTE: Authority cited: Section 15379.9 Government Code. Reference: Sections 15333.5, 15379.3 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (b) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5420. Importance of Grant Funding.

(a) The application shall discuss the importance of the grant funds for the viability of the project.

(b) The application shall describe other potential sources of funds for the requested amount of the grant. The application shall indicate whether any of these sources have been approached and have refused funding. The application shall indicate the result to the project if grant funds under the program are denied, postponed, or given in reduced amount.

(c) Projects indicating that they cannot proceed without the requested grant shall be deemed more likely to further the program goal in subsection (a) above, in connection with the agency staff review pursuant to Section 5425(d)(1) and (2).

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5421. Cost Sharing.

(a) The application shall include a calculation of the amount of grant funds as a percentage of total project funds.

(b) Projects indicating a greater ratio of non–grant funds (including in–kind contributions) to the requested grant shall be deemed more likely to further the program goal in subsection (a) above, in connection with the agency staff review pursuant to Section 5425(d)(1) and (2).

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (b) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5422. Small Businesses.

(a) The application shall discuss the extent to which small businesses if any, are expected to be involved in the project.

(b) The application shall include information regarding the potential involvement, if any, of small businesses either:

(1) as private sector participants;

(2) as subcontractors; or

(3) in any other capacity

(c) Projects indicating the involvement of small businesses shall be deemed more likely to further the program goal in subsection (a) above, in connection with the agency staff review pursuant to Section 5425(d)(1) and (2).

NOTE: Authority cited: Section 15378.99, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
3. Amendment of section heading, section and NOTE filed 9–18–95; operative 10–18–95 (Register 95, No. 38).

§ 5423. Program Priorities and Program Areas.

(a) The secretary shall be authorized, based upon advice of the committee, to announce a list of technologies or industries that shall constitute program priorities for purposes of the program. The secretary shall be authorized to modify the list of program priorities from time to time based upon advice of the committee.

(b) From time to time, the secretary shall be authorized to allocate or reallocate some or all of the available grant funds to specific program priorities.

(c) The agency shall provide the then–current list of program priorities, if any, and the level of available grant funds allocated for each priority, together with every application distributed to potential applicants. An application submitted for a project included in a then–current program priority shall not become ineligible for funding solely by virtue of the secretary subsequently removing such priority from the lit of program priorities.

(d) The Director shall be authorized to allocate each year's available program funds among the different program areas. The Director shall be authorized to set a maximum grant amount for each program area. Notwithstanding the foregoing, the Director shall be authorized, in his or her discretion, to reallocate funds among program areas, or exceed the maximum grant amount, in cases of extraordinary merit.

NOTE: Authority Cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15333.6, 15379.3 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsections (a)–(c) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5424. Funding Phases and Cycles.

(a) Applicants shall request funding for one of three funding phases listed below:

(1) Phase 0—Developmental phase, including preparing an application for Phase I or Phase II projects; must be completed within one (1) year after the date a grant agreement is executed.

(2) Phase I—A project scheduled to be completed within one (1) year after the date a grant agreement is executed.

(3) Phase II—A project scheduled to be completed in a period of more than one (1) but not more than three (3) years after the date a grant agreement is executed.

(b) The secretary shall be authorized to allocate the annual available funds for the program in several funding cycles that shall be announced throughout the year. The secretary shall be authorized to make grants in less than the amount set aside for any funding cycle or, in cases of extraordinary merit, to make grants in a greater amount, proportionately reducing available funding for future cycles. The agency shall determine and make public the date by which applications must be received to be eligible for each funding cycle.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3, 15379.4 and 15379.5, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsection (b) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5425. Action on Applications.

(a) The agency staff shall review each application to determine whether it is complete and complies with Section 5410. The agency staff shall notify an applicant that its application was determined to be incomplete or otherwise not in compliance with Section 5410 pursuant to Section 5428(d)(1).

(b) The agency shall review all complete applications based upon the information contained in the portions of the application described in Section 5410(b), (c), (d) and (f)(2) to determine whether the proposed project is eligible for funding. The agency staff shall notify an applicant that its application was determined to be ineligible for funding under the Act and these regulations pursuant to Section 5428(d)(1).

(c) Applications determined eligible pursuant to the review in subsection (b) above shall be submitted for peer review pursuant to Section 5427.

(d)(1) The agency staff shall review each application with (1) a positive peer review pursuant to Section 5427(d), or (2) a negative peer review but receiving an evaluation pursuant to Sections 5428(a) or 5431(d)(2), to consider the proposed project's ability to further the program goals contained in the Act and described in Sections 5417 to 5422.

(2) The agency staff shall prepare a report on each project that has received a review pursuant to subsection (d)(1) of this Section, discussing the degree to which it furthers each of the program goals.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3, 15379.4, 15379.5 and 15379.10, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5426. Conferences.

The agency shall be authorized to request an applicant to attend a conference with the agency staff and designees of agency staff, if the agency determines that such a conference would assist making revisions in, or supplements to, the application to increase the chances of successfully funding the applicant's request, or to assist the agency to better understand the application.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5427. Peer Review.

(a) Applications that have been determined eligible pursuant to Section 5425(b) shall undergo peer review by one or more persons with expertise in the scientific and technological aspects of the project.

(b) The agency staff shall transmit each completed application to the chair of the committee. Following consultation, to the maximum degree feasible, with the chair, agency staff shall assign to one or two members of the committee the task of conducting a peer review. If the agency staff, after such consultation with the chair of the committee determines that none of the members has sufficient expertise in the subject matter of the project, or determines that no qualified member of the committee is available to conduct a peer review, the agency staff shall engage a consultant or consultants to perform the peer review.

(c) The peer reviewer(s) shall assess the scientific and technological aspects of the project addressing the following questions:

(1) Are the scientific and engineering objectives of the project reasonable?

(2) Are the technology transfer aspects of the project appropriate and feasible?

(3) Are the project plans adequate to fulfill the project objectives?

(4) Is the project likely to lead to commercialization of a product(s), service(s) or process(es)?

(d) The reviewer[s] shall prepare a succinct report of their work, including an affirmative or negative conclusion in the questions in subsection (c) of this Section. Affirmative conclusions on all questions shall be deemed to be a positive peer review. A negative conclusion on any question shall be deemed a negative peer review. The reviewer(s) shall be authorized to conduct oral reviews with applicants in connection with questions in subsection (c) of this Section.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15333.6, 15379.3 and 15379.8, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.

2. Change without regulatory effect amending subsection (b) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5428. Final Action on Applications.

(a) An application receiving a negative peer review pursuant to Section 5427 shall be forwarded by the agency staff to the secretary. The secretary either shall not fund the grant request, or shall return such application to agency staff for evaluation pursuant to Section 5425(d)(1).

(b) The agency staff shall forward each application, together with all related material, to the secretary following completion of the peer review and staff review, pursuant to Section 5427 and Sections 5425(d)(1) and (2), respectively.

(c) The secretary's decision to award a grant shall be based upon:

(1) a finding that the project is eligible for funding:

(2) the peer review; and

(3) the agency staff review of program goals.

(d) Within one hundred and twenty (120) days after the agency's receipt of an application or, if the secretary has established funding cycles pursuant to Section 5424(b), after the deadline for submitting applications for any funding cycle, the agency shall notify the applicant that:

(1) the application is incomplete pursuant to Section 5425(a) or is ineligible pursuant to Section 5425(b);

(2) the secretary has approved or denied the grant request or approved a grant in a lesser dollar amount; or

(3) the funding decision has been deferred by the secretary until the next funding cycle.

(e) A determination that the application is incomplete or ineligible shall be accompanied by a written explanation and a description of what, if anything, can be done to remedy any deficiency. A denial of funding shall be accompanied by a written explanation of the reasons for such denial. Applicants for projects determined to be ineligible or which have been denied funding hereunder shall not be precluded from reapplying at any time for funding, nor shall they be precluded from requesting discretionary grants.

(f) If, subsequent to approving grants, the secretary determines that insufficient funds exist to fully fund all approved grants, the secretary shall be authorized to reduce or eliminate funding from some or all previously approved grants. Applicants with reduced or eliminated funding shall be so notified by a letter from the secretary mailed to the applicant.

(g) Following approval of a grant by the secretary pursuant to Section 5428 or Section 5431, the agency and the successful applicant shall enter into a grant agreement on terms mutually acceptable to all parties prior to funding of the grant.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.

2. New subsection (f) and relettering filed 12–15–92 as an emergency; operative 12–15–92 (Register 92, No. 51). A Certificate of Compliance must be transmitted to OAL 4–14–93 or emergency language will be repealed by operation of law on the following day.

3. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

Article 3. Grants

§ 5430. Multiyear Grants.

(a) Not less than ninety (90) nor more than one hundred and twenty (120) days prior to the anniversary date of a multiyear grant, the grantee shall provide to the agency a written report on the status of the project. Such report shall include:

(1) a discussion of how the project has met the scientific and technological goals stated in the application;

(2) a discussion of how the project has met each of the program goals set forth in Sections 5417 to 5422; and

(3) a financial statement detailing the expenditure of grant funds for project costs.

(b) The secretary shall be authorized but not required to forward such reports to the agency staff and other persons designated by the secretary for recommendations regarding continued funding.

(c) A decision regarding continued grant funding shall be based on the availability of funds, submission of the report required by this section and substantial compliance by the grantee during the preceding year with the terms and conditions of the grant agreement.

(d) Within forty–five (45) days of receipt of the report required by this section, the secretary shall notify the grantee in writing whether or not funding, if and when available, shall be continued for the next year.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.

2. Change without regulatory effect amending subsections (a), (b) and (d) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5431. Discretionary Grants.

(a) At the start of each fiscal year, the secretary shall establish the maximum amount of funds that shall be available during such fiscal year for discretionary technology transfer grants pursuant to Section 15379.10 of the Act. At any time, the secretary shall be authorized to award some or all of the funds set aside for discretionary grants to make grants to projects which pursue the regular application process in Article II.

(b) Applications for discretionary grants (including those for Phase 0) shall be made in the same form as an application submitted pursuant to Section 5410, but shall be clearly identified by the applicant as an application for a discretionary grant. Such application shall be in the same number of copies, and shall to the maximum extent feasible, contain the same information as is required by Section 5410. The applicant shall clearly identify those elements of program eligibility that are not met by the application, and shall indicate why the applicant believes a grant from the program is nonetheless justified.

(c) The agency staff shall process an application for a discretionary grant in the same manner as a regular application.

(d) An application for a discretionary grant that would be determined ineligible pursuant to Section 5425(b)(2), nevertheless shall be forwarded to the secretary for review. The secretary shall be authorized to either:

(1) return the application to the applicant as ineligible for funding, or

(2) direct the agency staff to continue processing the application.

(e) Nothing contained in these regulations shall prohibit the secretary from waiving any procedural requirement hereof and making a discretionary grant for a project, within the limits of Section 15379.10 of the

Act, without regard to any requirement of Sections 15379.3, 15379.4 or 15379.5 of the Act.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.3 and 15379.10, Government Code.

HISTORY

1. Repealer by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

Article 4. Confidentiality

§ 5440. Designation of Confidential Information.

No confidential information, or information that is the subject of a pending application, shall be disclosed except as provided by Section 5441, unless disclosure is ordered by a court of competent jurisdiction.

(a) Any person giving custody or ownership of information to the agency shall indicate any desire that it be designated confidential information and not publicly disclosed, but failure to so indicate at the time the information is submitted to the agency is not a waiver of the right to request confidentiality later. A request for confidential designation shall:

(1) be on a sheet or sheets separate from but attached to the information;

(2) specifically indicate those parts of the information which should be kept confidential;

(3) state the length of time the information should be kept confidential, and provide justification for the length of time;

(4) cite and discuss (i) the provisions of the Public Records Act (California Government Code 6250 et seq.) or other law that allows the agency to keep the information confidential, and (ii) the public interest in nondisclosure of the information. If it is believed that the record should not be disclosed because it contains trade secrets or its disclosure would otherwise cause loss of a competitive advantage, the request shall also state the specific nature of the advantage and how it would be lost, including the value of the information to the requesting party, and the ease or difficulty with which the information could be legitimately acquired or duplicated by others;

(5) state whether and how the information is kept confidential by the requesting party and whether it has ever been disclosed to a person other than an employee of the requesting party, and if so under what circumstances;

(6) contain the following certification executed by the person primarily responsible for preparing the request: "I certify under penalty of perjury that the information contained in this request for confidential designation is true, correct, and complete to the best of my knowledge, and that I am authorized to make this request and certification on behalf of [name of entity]"; and

(7) specify whether the person submitting the request wishes the information returned or disclosed upon a denial of confidential designation; information returned to requesting party shall not be considered or reviewed as part of any application for grant funding to the agency.

(b) If the information contains information which the requesting party has received from another party who has demanded or requested that the requesting party maintain the confidentiality of the information, the requesting party shall address the items in Section 5440(a) to the greatest extent possible and shall explain the request made by the original party and the reasons expressed by the original party.

(c) An incomplete request shall be returned to the requesting party with a statement of its defects. The information for which confidentiality was requested shall not be disclosed for thirty (30) days after return of the request to the requesting party to allow a new request to be submitted.

(d) If a requesting party's prior request for confidential designation of substantially similar information has been granted, a request for confidential designation shall be deemed granted if the request contains a certification that the information submitted is substantially similar and that all facts and circumstances relevant to the granting or approval of the request are unchanged.

(e) The secretary shall determine if a request for confidential designation should be granted. A request shall be granted unless the requesting party has failed to make any reasonable claim that the Public Records Act or other provision of law authorizes the agency to keep the information confidential, and upon a finding by the agency that there is a public interest in nondisclosure of the information. The secretary shall be authorized, within thirty (30) days after receipt of a request, to require the requesting party to submit any additional information necessary to rule on the request. If the additional information is not returned to the agency within fourteen (14) days of agency mailing of the request, the secretary shall deny the request. The secretary's determination shall be in writing and shall be mailed no later than sixty (60) days after receipt of a request or thirty (30) days after receipt of additional information, whichever is later. There shall be no administrative appeal from the secretary's decision. The information sought to be designated confidential shall not be available for inspection or copying for a period of 30 days after the denial of a request, during which time the requesting party may appeal such denial to a court of competent jurisdiction.

NOTE: Authority cited: Sections 6253(a) and 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending subsections (a), (a)(4), (a)(7) and (e) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5441. Disclosure of Confidential Information.

(a) The secretary shall be authorized to disclose information determined confidential pursuant to Section 5440 to:

(1) Agency employees whose agency work requires inspection of the information.

(2) Persons under contract to the agency whose work for the agency requires inspection of the information and who agree in a contract to keep the information confidential.

(3) Other governmental bodies which have a need for the information related to their official functions and which agree to keep the information confidential and to disclose the information only to those employees whose agency work requires inspection of the information. On behalf of the agency the secretary shall be permitted to request and agree to maintain the confidentiality of other agencies' confidential information.

(4) Any person, provided that either (i) the requesting party has consented in writing to the disclosure, or (ii) the secretary, after prior notice to the requesting party and opportunity for the requesting party to be heard, determines that such information is not exempt from disclosure under the Public Records Act and the public interest in disclosure of such information outweighs the public interest in nondisclosure.

(b) The secretary shall advise the person to whom the materials with the confidential designation belong of the disclosure to persons in subsections (a), (2), (3) and (4) of this Section of information determined confidential pursuant to Section 5440.

NOTE: Authority cited: Sections 6253(a) and 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5442. Security of Confidential Information.

The secretary is responsible for maintaining the security of confidential information.

NOTE: Authority cited: Sections 6253(a) and 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

§ 5443. Delegation of Authority and Responsibilities.

The secretary shall be authorized to delegate any authority, duties or responsibilities under this Article to any employee of the department.

NOTE: Authority cited: Sections 6253(a) and 15379.9, Government Code. Reference: Sections 15333.5 and 15379.3, Government Code.

HISTORY

1. Repealed by operation of Government Code section 11346.1(g) and new section filed 8–20–89; operative 8–20–89 (Register 89, No. 31). For prior history, see Register 89, No. 2.
2. Change without regulatory effect amending section filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

Article 5. Consortia

§ 5450. Consortium Development.

In addition to the requirements of Section 5410, an application for consortium development must include plans for developing a consortium for which all the following are or will be true by the end of the project term:

(a) the consortium is administered by a governing board;

(b) the governing board adopts a technology agenda of priority areas for funding which reflects the technology transfer needs of the industry members of the consortium and the technology available for commercialization from the scientific community. Not less than twice a year the board shall review the agenda, and determine whether changes are required to the agenda. As used in this section, "technology agenda" means a priority listing of commercialization needs;

(c) the consortium conducts an ongoing outreach and marketing program to disseminate the technology transfer needs of the industry members to the scientific community, and to obtain information regarding the technology available for commercialization from the scientific community; and

(d) the consortium has a written, board approved plan for implementing the projects funded by the consortium. The plan shall include concrete steps required for the industry members to adopt and use the commercialization which results from the funded projects.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.1 and 15379.3, Government Code.

HISTORY

1. New section filed 9–8–92 as an emergency; operative 9–8–92 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–8–93 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 3–8–93 order transmitted to OAL 9–2–93 with amendments and filed 10–18–93 (Register 93, No. 43).
4. Editorial correction amending HISTORY 1 and 2 (Register 93, No. 43).

§ 5451. Sub–Solicitation Requirements.

(a) An applicant shall be eligible to submit an application for a consortium project to fund sub–projects if the applicant is a consortium meeting all the requirements of Section 5450.

(b) The only circumstance under which an applicant shall be authorized to submit an application without identifying the specific projects to be funded is when a sub–solicitation will be used by a consortium project. Such projects require a sub–solicitation when state funds will be awarded to third parties pursuant to an application process to occur after the grant is awarded to the applicant. No funds shall be disbursed or expenses incurred for awards to third parties pursuant to a sub–solicitation until the agency has approved in writing the applicant's compliance with the subsection (c) requirements.

(c) A sub–solicitation shall be approved by the agency upon compliance with all of the following:

(1) the sub–solicitation is approved by the governing board of the consortium;

(2) the sub–solicitation prohibits discrimination by applicants, and requires compliance with state and federal anti–discrimination laws;

(3) the sub–solicitation specifies that upon award of a sub–solicitation grant, the parties shall execute an agreement which includes the requirements contained in the State Administrative Manual covering contracts between the state and contractors. The agreement shall be solely between the applicant and the sub–solicitation grantee, except for any indemnification clauses, which shall benefit the state;

(4) the sub–solicitation must be advertised both within the scientific and business community served by the consortium and to other interested parties;

(5) the sub–solicitation must state that:

(A) costs will be paid on a cost reimbursement basis;

(B) the issue of ownership and use of intellectual property will be resolved in the sub–solicitation grant agreement;

(C) sub–solicitation applicants must list all companies which will participate in the project, and if no companies will participate, must specify why;

(6) the sub–solicitation must include provisions for repayment of the grant to the consortium in the event of material non–compliance with the agreement:

(7) the sub–solicitation subject area is consistent with the consortium's technology agenda as that term is defined in Section 5450(b); and

(8) the process used to select winning sub–solicitation projects must be in writing, include objective criteria based upon a competitive process, and be approved by the consortium governing board;

(9) projects funded pursuant to a sub–solicitation must include a plan for management of the project while it is being funded; and

(10) the governing board of the consortium must establish a time line for regular review of the project, including the type of review to be conducted. This review shall be conducted by either the governing board or its designated representative.

(d) The agency shall be a member of the panel selected by the consortium to review sub–solicitations.

(e) All agreements with sub–solicitation grantees must be reviewed and approved by the department.

NOTE: Authority cited: Section 15379.9, Government Code. Reference: Sections 15333.5, 15379.1 and 15379.3, Government Code.

HISTORY

1. New section filed 9–8–92 as an emergency; operative 9–8–92 (Register 92, No. 37). A Certificate of Compliance must be transmitted to OAL by 3–8–93 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3–8–93 as an emergency; operative 3–8–93 (Register 93, No. 11). A Certificate of Compliance must be transmitted to OAL by 9–8–93 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 3–8–93 order transmitted to OAL 9–2–93 with amendments and filed 10–18–93 (Register 93, No. 43).
4. Editorial correction amending HISTORY 1 and 2 (Register 93, No. 43).
5. Change without regulatory effect amending subsections (b), (c) and (d) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).

Article 6. Regional Technology Alliances

§ 5460. Definitions.

The following terms shall have the meanings set forth below:

(a) "Alliance" means a Regional Technology Alliance as defined in Government Code section 15379.2.

(b) "Applicant" means the Person(s) who submits the Solicitation to the Office.

(c) "DSTI" means the Division of Science, Technology and Innovation within the California Technology, Trade & Commerce Agency.

(d) "Match" means cash and In–Kind Contributions available for expenditure upon designation of an Alliance.

(e) "Person" means an individual, a corporation, a partnership, a joint venture, an association, a joint stock company, a trust, or an unincorporated organization.

(f) "Region" means the geographic area which will be served by an Alliance. The initial Region shall be specified in the Solicitation.

(g) "Small Business" means that term as defined in section 5400(mm).

(h) "Solicitation" means the application for designation as an Alliance containing the section 5463 information.

NOTE: Authority cited: Sections 15329 and 15378.99, Government Code. Reference: Sections 15329, 15333.5, 15379.2, 15346.3 and 15346.7, Government Code.

HISTORY

1. New article 6 and section filed 10–21–93 as an emergency; operative 10–21–93 (Register 93, No. 43). A Certificate of Compliance must be transmitted to OAL by 4–18–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 10–21–93 order including repealer of subsections (e)–(e)(3), subsection redesignation and amendment of NOTE transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).
3. Repealer of subsections (d)–(d)(3), (f)–(g)(3) and (m)–(m)(3), subsection relettering, and amendment of newly designated subsection (g) filed 9–28–95; operative 10–28–95 (Register 95, No. 39).
4. Change without regulatory effect repealing and adopting new subsection (c), repealing subsection (e), relettering subsections and amending NOTE filed 1–8–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 2).

§ 5461. Solicitation Process.

(a) The DSTI shall place an advertisement at least once in the California State Contracts Register informing the public that the DSTI will commence within a specified time period a designation process for an Alliance.

(b) Every Person requesting an opportunity to become an Alliance shall be mailed a Solicitation.

(c) All Solicitations received by the due date specified in the Solicitation shall be reviewed by the DSTI to determine eligibility pursuant to section 5462.

(d) All eligible Solicitations shall be scored by DSTI staff and consultants, based upon the Section 5464 criteria.

(e) The Applicant scoring the most points within each Region shall be recommended to the DSTI, along with a description of the proposed Alliance.

(f) The DSTI shall approve the Applicant(s) recommended for designation if it finds the description of the organization is consistent with the role and responsibilities of an Alliance as specified in statute.

(g) If the DSTI disapproves the Applicant, the DSTI shall recommend the second highest scoring Applicant within the proposed Region. This process shall continue until either the DSTI approves an Applicant, or all eligible Applicants are disapproved, in which case the DSTI shall hold a new Solicitation process consistent with the procedures set forth in this section.

(h) Not later than forty–five calendar days from the deadline for submitting Solicitations, the DSTI shall place in the mail a notification to all Applicants informing them of whether they have been conditionally designated as an Alliance. The notification to conditionally designated Alliances shall require the applicant incorporate as an Alliance, or demonstrate that it has previously incorporated as an Alliance.

In order to meet the requirement that the Applicant incorporate as an Alliance, the corporation: must be a nonprofit corporation registered with the California Secretary of State; the purpose of the corporation, as stated in its articles of incorporation, must be consistent with Government Code section 15379.2; and the date of incorporation shall not proceed the Solicitation deadline.

(i) Subsequent to designation of an Alliance, the Office and Alliance shall agree to the terms of a contract specifying the services which the Alliance shall provide. The parties shall be authorized to expand or shrink the size of the Region by amending the contract.

NOTE: Authority cited: Sections 15329 and 15378.99, Government Code. Reference: Sections 15346.6 and 15379.2, Government Code.

HISTORY

1. New section filed 10–21–93 as an emergency; operative 10–21–93 (Register 93, No. 43). A Certificate of Compliance must be transmitted to OAL by 4–18–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 10–21–93 order including amendment of subsection (h), new subsection (i) and amendment of NOTE transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).
3. Change without regulatory effect amending subsections (a) and (c)–(h) and amending NOTE filed 1–8–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 2).

§ 5462. Eligibility.

A Solicitation is eligible only if it meets all of the following criteria:

(a) The Alliance will locate its principal place of business within the Region;

(b) Fifty–one percent (51%) of the Persons comprising the Applicant have their address within the Region;

(c) The amount of funds requested from the DSTI does not exceed the available funding specified in the Solicitation (if specified); and

(d) The Solicitation demonstrates that the Applicant has at least two dollars of Match for every dollar of funds requested from the DSTI.

NOTE: Authority cited: Sections 15329, 15346.9 and 15378.99, Government Code. Reference: Sections 15346.6 and 15379.2, Government Code.

HISTORY

1. New section filed 10–21–93 as an emergency; operative 10–21–93 (Register 93, No. 43). A Certificate of Compliance must be transmitted to OAL by 4–18–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 10–21–93 order including amendment of NOTE transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).
3. Change without regulatory effect amending subsections (c) and (d) and amending NOTE filed 1–8–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 2).

§ 5463. Solicitation Content.

(a) The Solicitation shall consist of a cover sheet form (Regional Technology Alliance Solicitation, 10/93 revision date) and attachments as set forth in subsection (c). Each attachment shall begin on a separate sheet of paper with the item number and title at the top of the page.

(b) The cover sheet shall be signed by an authorized representative of each Person comprising the Applicant, and shall identify the following:

(1) The name and address of each Person submitting the Solicitation;

(2) The name, address, phone number and fax number of the Applicant's authorized representative;

(3) The proposed Alliance name and address;

(4) The requested support funds from the DSTI for the first year of operation;

(5) The total support budget of the Alliance during the first year of operation;

(6) Whether confidential information is included in the Solicitation; and

(7) An abstract of the services to be provided by the proposed Alliance.

(c) The Solicitation shall contain attachments which address each of the following:

(1) The budget, consisting of:

(A) An identification of all sources and uses of funds and the estimated value of all In–Kind Contributions.

(B) A beginning and end date, with a total duration of one year. The budget shall begin seventy–five calendar days following the deadline for submitting Solicitations.

(C) Budget information shall be provided in at least the following categories: personnel, contract services, travel, space, equipment, and other costs.

(2) A comprehensive assessment of the economic development needs within the Region. The assessment shall include, but not be limited to, the following:

(A) Prioritization of the needs;

(B) Results of a survey conducted within the Region business community, assessing the needs of the business community;

(C) Evidence that the Region business community supports the methodology and results of the assessment;

(D) Evidence that the assessment is based upon practical versus hypothetical analysis, utilizing actual not theoretical conditions; and

(E) An analysis of the factors causing the economic development needs within the Region. Particular attention shall be placed on the impact of Region defense industry cutbacks.

(3) An organizational plan addressing the Alliance's ability to address the needs identified in subsection (c)(2).

(4) An implementation plan that serves as a blueprint for the steps the Alliance will take to implement the subsection (c)(3) organizational plan.

(5) Evidence of active industry participation and support in the Alliance. Participation and support must be identified by company name, and are evidenced by the following:

(A) Percentage of the Alliance board of directors from industry, and the number of industry board members who are officers, and serve on the executive committee;

(B) Financial commitments by industry,including membership dues and other committed funds;

(C) Alliance or Applicant activities undertaken or committed by industry; and

(D) Other tangible industry support and participation.

(6) Participation, support and coordination among academic, federal laboratories, labor, the financial sector, and local government.

(7) Management capacity, including knowledge of and experience with state contracting procedures. Include a resume for all proposed management employees and discuss their experience in managing or working with similar organizations or projects. If some or all of the individuals have not been selected, include proposed job description(s).

(8) Applicant's experience and expertise in the delivery of services and resources, programs and activities addressing technology development, commercialization, application and competitiveness within the Region. Applicant shall specifically address the area of defense industry conversion and diversification.

(9) Show how the Alliance will network with other Persons in both its Region and in other parts of California to increase the effectiveness of the Alliance.

(10) Discuss the inclusion of Small Business as a member(s) of the Alliance, a member(s) of the board of directors and included in Alliance programs and activities.

(11) Demonstrate that the budget for the Alliance, both for support and for projects and activities, is cost effective.

(12) Demonstrate that the Alliance membership and board of directors represent diversity geographically, by industry and by types of industry (e.g. high technology and basic manufacturing).

(13) Ability to raise funds. The Solicitation shall address funds raised for Alliance activities by the Applicants in the last two years, probable sources of funds within the next year and commitments from industry and the federal government.

(14) List of defense conversion projects with which Applicant is currently involved, including name of project, budget total, name of entity responsible for the project, commercial objective (e.g. cleaner process for producing glass) and projected results (e.g. jobs created, products launched).

(d) Applicant shall submit one (1) signed and clearly identified original and two (2) copies of the Solicitation in a single package to the address specified in the Solicitation.

(e) All confidential material included in a Solicitation shall be segregated on separate pages stamped "Confidential" at the top and bottom. Material designated confidential by the Applicant shall be cross referenced to that part of the Solicitation to which it relates.

(f) An Applicant shall be authorized to withdraw an application at any time by written request to the DSTI.

NOTE: Authority cited: Sections 15329 and 15378.99, Government Code. Reference: Section 15379.2, Government Code.

HISTORY

1. New section filed 10–21–93 as an emergency; operative 10–21–93 (Register 93, No. 43). A Certificate of Compliance must be transmitted to OAL by 4–18–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 10–21–93 order including amendment of NOTE transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).
3. Amendment of subsection (c)(10) filed 9–28–95; operative 10–28–95 (Register 95, No. 39).
4. Change without regulatory effect amending subsections (b)(4) and (f) and amending NOTE filed 1–8–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 2).

§ 5464. Scoring Solicitations.

All eligible Solicitations received by the deadline established in the Solicitation shall be scored using the below listed criteria. More points are awarded for Solicitations which better address the criteria.

(a) Economic development needs within the Region comprehensively assessed. More points will be awarded to projects in which:

(1) A coherent prioritization of needs is included that is consistent with the materials presented in the remainder of the Solicitation.

(2) Evidence is provided that the Region business community supports the methodology and results of the assessment.

(3) The needs are based, at least in part, on the results of a survey conducted within the Region business community.

(4) The assessment is based upon the actual conditions existing in the area, and not on a theoretical analysis of the situation.

(5) The assessment includes a convincing description and analysis of the cause of the need, including the impact of Region defense cuts.

Points awarded: 1 to 10.

(b) A coherent organizational plan that addresses the Alliance's ability to address the needs identified. More points will be awarded to plans that are credible and that are consistent with resource constraints.

Points awarded: 1 to 10.

(c) An implementation plan that serves as a blue print for the steps the Alliance will take to implement the organizational plan. More points will be awarded to plans that are realistic and require the least amount of development versus program implementation.

Points awarded: 1 to 10.

(d) Evidence of active industry participation and support in the Alliance. More points will be awarded to Solicitations that demonstrate that industry representatives will be:

(1) Committing to undertake joint activities with the Alliance or Applicant.

(2) Committing resources to the Alliance;

(3) Members of the Alliance;

(4) Dues paying members of the Alliance;

(5) Members of: the board of directors, executive committee and/or are officers of the Alliance; and

(6) A majority of the members of the board of directors (most points possible).

Points awarded: 1 to 10.

(e) Leverage of state funds, defined as the support funds requested in the budget from the DSTI as a percentage of the entire support budget. A budget with more than 33% DSTI funds shall receive 2 points. A budget with 25–33% DSTI funds shall receive 4 points. A budget with 20–25% DSTI funds shall receive 6 points. A budget with 15–20% DSTI funds shall receive 8 points, and a budget with under 15% DSTI funds shall receive 10 points.

(f) Participation, support and coordination among academic, federal laboratories, labor, the financial sector and local government. A Solicitation shall receive more points for demonstrating that each category is involved in the Alliance, and for the number of individual Persons involved. Involvement is defined exclusively as being a dues paying member of the Alliance, being a member of the board of directors, or contractually involved in a program or activity with the Alliance.

Points awarded: 1 to 10.

(g) Management capacity, including knowledge of and experience with state contracting procedures. More points will be awarded to Solicitations that have identified personnel for key management positions, for

management that has relevant experience, and for job descriptions or resumes evidencing experience with State of California contracting procedures.

Points awarded: 1 to 10.

(h) Applicant's experience and expertise in the delivery of services and resources, programs and activities addressing technology development, commercialization, application and competitiveness within the Region. More points will be awarded to those Solicitations which demonstrate experience and expertise in the area of defense industry conversion and diversification.

Points awarded: 1 to 10.

(i) Evidence that the Alliance will effectively network with other Persons in its Region and in other parts of California to increase the effectiveness of the Alliance. More points will be awarded to Solicitations which demonstrate experience with computer networks.

Points awarded: 1 to 10.

(j) The inclusion of Small Business as a member(s) of the Alliance, a member(s) of the board of directors and included in Alliance programs and activities. More points will be awarded to those Solicitations including a wide variety and number of these businesses, in a variety of roles. Most points will be awarded to those Solicitations including these businesses on the board of directors.

Points awarded: 1 to 10.

(k) The budget for the Alliance, both for support and for projects and activities, is cost effective. More points will be awarded to those Applications where the complexity and number of projects which the Applicant has identified in section 5463(c)(14) is high in proportion to the size of the support budget.

Points awarded: 1 to 10 points.

(*l*) The Alliance membership and board of directors represent diversity by industry and by types of industry (e.g. high technology and basic manufacturing). More points will be awarded to industries with small and medium sized defense manufacturers and or suppliers represented on the board of directors.

Points awarded: 1 to 10. points.

(m) Ability to raise funds. More points will be awarded to Solicitations which can demonstrate a history of successful fundraising for the type of activities for which the Alliance will need to raise funds.

Points awarded: 1 to 20.

(n) The Alliance membership and board of directors represent the entire Region.

Points awarded: 1 to 30 points.

NOTE: Authority cited: Sections 15329 and 15378.99, Government Code. Reference: Section 15379.2, Government Code.

HISTORY

1. New section filed 10–21–93 as an emergency; operative 10–21–93 (Register 93, No. 43). A Certificate of Compliance must be transmitted to OAL by 4–18–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 10–21–93 order including amendment of NOTE transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).
3. Amendment of subsection (j) filed 9–28–95; operative 10–28–95 (Register 95, No. 39).
4. Change without regulatory effect amending subsection (e) and amending NOTE filed 1–8–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 2).

§ 5465. Confidentiality.

Any Solicitation with material designated as confidential shall comply with the procedures contained in sections 5440 through 5443.

NOTE: Authority cited: Sections 15329 and 15378.99, Government Code. Reference: Sections 15346.6 and 15379.2, Government Code.

HISTORY

1. New section filed 10–21–93 as an emergency; operative 10–21–93 (Register 93, No. 43). A Certificate of Compliance must be transmitted to OAL by 4–18–94 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 10–21–93 order including repealer of subsection designation and amendment of NOTE transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).
3. Change without regulatory effect amending NOTE filed 1–8–2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 2).

§ 5466. In–Kind Contributions.

As used in this article, "in–kind contributions" means the value of personnel, equipment and facilities provided by the Alliance, or for use by the Alliance which meets the following requirements:

(a) In–kind contributions of personnel shall be valued based upon the salary of such personnel, plus benefits. In–kind contributions of personnel shall only comprise personnel that will directly participate, and can be specifically identified with, the Alliance. No in–kind contributions of personnel less than 50% of that person's time shall be included as Match.

(b) In–kind contribution of equipment shall meet the following criteria:

(1) The total contribution of equipment must be no more than 20% of the matching contributions;

(2) Contributed equipment must be used exclusively by the Alliance; and

(3) For the purposes of Match, equipment shall be valued at its book value.

(c) In–kind contribution of facilities shall consist only of facilities used by the Alliance, and the only contribution which shall be included as Match is that percentage of the use of the facilities attributable to the Alliance.

NOTE: Authority cited: Sections 15378.99 and 15346.9, Government Code. Reference: Section 15346.7, Government Code.

HISTORY

1. Certificate of Compliance as to 10–21–93 order including adoption of new section transmitted to OAL 3–3–94 and filed 4–13–94 (Register 94, No. 15).

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Title 10. Investment

Chapter 7.71. Defense Conversion Matching Grant Program

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Chapter 7.71. Defense Conversion Matching Grant Program

§ 5470. Definitions.

The following terms shall have the meanings set forth below:

(a) "Act" means Chapter 5.8 (commencing with Section 8445) of Division 1 of Title 2 of the California Government Code and Chapter 3.5 (commencing with Section 15378.98) of Part 6.7, Division 3, Title 2 of the California Government Code.

(b) "Alliance" means a regional technology alliance designated pursuant to Sections 5460 through 5465.

(c) "Applicant" means the Person(s) who submit the Solicitation to the Office or Alliance.

(d) "Council" means the Defense Conversion Council established in Government Code sections 15346.2 and 15346.3.

(e) "Defense Conversion" means the transition from defense to civilian markets caused by reduction in federal spending on national defense, including military base closures and the shifting missions of federal laboratories resulting in job losses in defense industries and among suppliers to those industries.

(f) "Dual Use" means products, services, standards, processes, or acquisition practices, respectively, that are capable of meeting requirements for defense and non–defense application.

(g) "Funding Agency" means a California State public entity, other than the Office, offering to fund Projects.

(h) "Funding Sources" includes, but is not limited to, the Office, Funding Agencies and federal agencies offering funding under a Solicitation.

(i) "Grant" means funding for a Project provided under the Act in the form of payment(s) to an Applicant pursuant to a Grant Agreement.

(j) "Grant Agreement" means any written contract entered into between the Office and an Applicant that is recommended for funding by the Council and approved by the Office to provide a Grant to fund a Project on such terms and conditions as shall be required by the Office and agreed to by the Applicant.

(k) "In–Kind Contributions" means the value of personnel, equipment, facilities and other contributions provided to the Project. In the event that a Solicitation is used to provide matching funds for a specific other funding source that has a definition of in–kind contributions, that definition shall be utilized for that specific Solicitation, and the definition shall be included in the Solicitation. In–Kind Contributions of personnel shall only comprise personnel that will directly benefit from, and can be specifically identified with, the Project.

(*l*) "Match" means the Project cash and In–Kind Contribution by person(s) other than the Office, Funding Agencies and the federal government.

(m) "Office" means the Office of Strategic Technology within the Trade and Commerce Agency.

(n) "Person" means an individual, a corporation, a partnership, a joint venture, an association, a joint stock company, a trust, or an unincorporated organization.

(o) "Product" means the product, process or service expected to result from the Project.

(p) "Product Commercialization" means the movement of Products toward markets.

(q) "Project" means an endeavor designed to achieve Product Commercialization which the Proposal recommends be funded by the State of California.

(r) "Proposal" means the completed Solicitation forms and attachments described in Section 5473.

(s) "Region" means the geographic area served by an Alliance, or if no Alliance exists, the Office.

(t) "Small Business" means a business or nonprofit corporation as defined in Section 5400(mm).

(u) "Solicitation" means the form sent to Persons pursuant to Section 5471.

(v) "Very Small Business" means a business or nonprofit corporation which qualifies for the California small business preference pursuant to Government Code Section 14835 et seq. and the regulations promulgated thereunder.

NOTE: Authority cited: Sections 8456, 15378.99 and 15346.9, Government Code. Reference: Sections 8445, 15346.2, 15379.2(a), 15379.3, 15379.4 and 15379.7, Government Code.

HISTORY

1. New chapter 7.71 and section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New chapter 7.71 and section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).
4. Repealer of subsections (f)–(f)(3), (n)–(o)(3) and (z)–(z)(3), and subsection relettering filed 9–26–95; operative 10–26–95 (Register 95, No. 39).

§ 5471. Solicitation Process.

(a) The Office shall prepare a Solicitation each time it proposes to award Grant funds, which shall include the deadline for submission of Proposals. The Office shall be authorized in a Solicitation to limit the amount for which the Office shall provide matching funds.

(b) A Solicitation shall be mailed to every Person requesting a copy.

(c) All Proposals received by the due date and place specified in the Solicitation shall be reviewed to determine eligibility pursuant to section 5472. Applicants shall include in the Proposal package both a signed original and five copies of the Proposal. Only eligible Proposals shall be scored.

(d) The Solicitation shall describe the Region covered by each Alliance. The Proposal shall be mailed to the Alliance covering the Region where the Applicant's Project will take place. If a Project will take place in a Region not covered by an Alliance, or is statewide in nature, the proposal shall be mailed to the Office. As used in this subsection, "statewide in nature" means that a substantial portion of the Project will take place in more than one Region.

(e) The Alliances and Office shall review the Proposals assigned to each for eligibility, and evaluate and score the eligible Proposals according to the Section 5474 criteria. No two proposals shall receive the same score. Alliances and Funding Agencies shall be included as nonvoting participants in the Office review, and the Office and Funding Agencies shall be included as nonvoting participants in the Alliance reviews.

(f) The Alliances and the Office shall forward to the Office all eligible Proposals scoring a minimum of 25 points.

(g) The Office shall establish review panels approved by the Council, including a nonvoting representative from each Alliance and two or more voting members, including one or more representatives from Funding Agencies. The review panels shall review the Proposals forwarded by the Alliances and the Office and make a single, consolidated, ranked list of Proposals complying with Section 5475(a) and is ranked according to Section 5475(b) criteria. The list shall only include Proposals for which funding is available, based upon Proposals scoring the most points. If two or more proposals near the bottom of the ranking have identical scores and if there is money to fund some but not all identically ranked proposals, then there shall be oral interviews. The purpose of the oral interviews is to re–rank the tied proposals.

(h) The Office shall forward to the Council and the Alliances the proposed funding list, with a short description of each Proposal on that list. The description shall address each of the subsection (i)(1) through (3) items. Proposals will be sent to the Council upon request.

(i) No later than 60 days following the deadline for submitting Proposals, the Council shall recommend funding for those Proposals receiving the highest ranking from the review panel, unless the Council finds that changes to the ranking are necessary due to:

(1) Failure of the Proposal to score sufficient Section 5475 points to receive funding;

(2) Conflict of interest as defined by Government Code Sections 1090 or 87100 et seq.; or

(3) Lack of geographic diversity.

(j) The Council shall remove from the ranking any Proposal which: lacks geographic diversity, includes a conflict of interest or fails to score sufficient Section 5475 points to receive funding. The Council shall specify which standard has not been met and shall fund the next highest ranking proposal(s) which meet the subsection (i)(1) through (3) criteria.

(k) The Council shall make the recommendation in writing by mailing notification to the Applicant, the Office, the Funding Agency and the Alliances.

(*l*) Following the Council recommendation of a Proposal which requested Office funding, the Office and the successful Applicant shall enter into a Grant Agreement on terms mutually acceptable to all parties.

(m) At the Council funding meeting, an Alliance shall be authorized to appeal to the Council a review panel Proposal ranking or finding of eligibility. The Council shall overturn the ranking only if it finds clear and convincing evidence that the finding or ranking was unsubstantiated.

NOTE: Authority cited: Section 8456, Government Code. Reference: Sections 8447, 8449, 8450, 8451, 8452, 8453 and 8454, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).

§ 5472. Eligibility.

A Proposal is eligible if it meets all of the following criteria:

(a) Identifies the sources of funding for the entire Project.

(b) Demonstrates that the requested Office or Funding Agency funds will not supplant other Project funding.

(c) Demonstrates that at least 75% of the Project will be performed in California.

(d) The amount requested for Office funding does not exceed 25% of the Project cost.

(e) At least 25% of the Project costs are provided by Match secured from sources other than the federal and/or state government(s). The minimum cash Match is as follows:

(1) Very Small Business: 10%

(2) Small Business: 30%

(3) Other Applicants: 50%

In calculating the above, the numerator is cash Match and the denominator is twenty–five percent of the Project cost.

(f) The Project meets the definition of Dual Use.

(g) The Project meets any eligibility requirements of other Project Funding Agencies.

(h) A minimum of 20% of the Project costs is provided by an agency of the federal government.

NOTE: Authority cited: Section 8456, Government Code. Reference: Sections 8451, 8453 and 15379.4, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).

§ 5473. Solicitation and Proposal.

(a) The Solicitation ("Defense Conversion Matching Grant Program Solicitation," 2/94 revision date) shall consist of a cover sheet, budget, index and list of attachments as set forth in subsection (e).

(b) The cover sheet shall include a requirement that it be signed by an authorized representative of Applicant, and shall identify the following:

(1) The Applicant.

(2) The name, address, telephone number, and facsimile number of the Applicant's authorized representative.

(3) The Project name (short title).

(4) The requested funds from the Office and, if applicable, Funding Agency for the first year of the Project.

(5) The total budget of the Project during the term specified in the Solicitation.

(6) Whether confidential information is included in the Proposal.

(7) A short summary of the Project.

(8) Region where Project will take place, or that Project is statewide in nature.

(9) Certification that the requested funds will not supplant other Project funding.

(10) Certification that at least 75% of the Project will be performed in California.

(c) A budget shall contain the following information:

(1) Identification of all sources and uses of funds and the estimated value of all In–Kind Contributions.

(2) A beginning and end date, with a total duration as specified in the Solicitation. The budget shall begin sixty days following the Proposal due date and shall be divided into annual increments.

(3) Budget information provided in at least the following categories: personnel, contract services, travel, space, equipment, overhead and other costs.

(4) A list of all personnel, including a description of: cost, job classification and percentage contribution to the Project.

(5) For each subcontract included in the budget, identification of the subcontractor by name or inclusion of a description of the work to be performed, total cost of the subcontract and the proposed budget.

(d) Cross–reference index shall indicate Proposal page number location of subsection (e)(1) through (9) information.

(e) The Solicitation shall request the following attachments and any other information Applicant wishes to provide:

(1) The Project description consisting of:

(A) A clearly identified description of the Product(s).

(B) A description of the marketing strategy, including a description of the intended market niche, market need, marketing dynamics and assessment of potential barriers to marketing.

(C) The means of capitalization of the Product(s), including the capital, personnel and property dedicated for marketing the Product(s).

(D) A comprehensive discussion of commercial production of the Product and its relevance to Dual Use.

(E) Discussion of engineering, research and development necessary to commercialize the Product(s).

(F) The plan for completion of the Project and for commercialization of the Product after completion of the Project.

(G) A concrete discussion of how successful commercialization of the Product will increase jobs and tax revenues, and improve the California economy.

(2) A description of how the Applicant will network with other Persons in both its Region and in other parts of California to increase the effectiveness and commercialization of the Product.

(3) A description of how Small Business is included as members of the Applicant, members of the Applicant boards of directors and participants in the Project.

(4) Information demonstrating that the budget for the Project, both for administration and overhead and for Project activities, is cost effective.

(5) A description of all links with Small Business Development Centers, the California Manufacturing Excellence Program, the California Supplier Improvement Program, and with business incubators and local education and business training institutions.

(6) A description of the need for the Project and how the Project will directly respond to identified local or regional economic needs.

(7) A description of management capacity, including a requirement that the Proposal include a resume for key proposed Project management

employees or consultants and discuss their experience in managing or working with similar organizations or projects. If some or all of the individuals have not been selected, include proposed job description(s).

(8) A discussion of the management Plan, including a description of the Project management and how successful management of the Project will result in commercial viability.

(9) If applicable, a description of the Project's training component to upgrade the skills of the Project's workers, and/or the skills of other California workers.

(10) A statement indicating whether Applicant is the entity which will perform the Project. If another entity will perform the Project, identify entity's name, address, telephone and facsimile numbers and describe the relationship of Applicant to that entity.

(f) All confidential material included in a Proposal shall be segregated on separate pages stamped "Confidential" at top and bottom. Material designated confidential by the Applicant shall be cross referenced to that part of the Solicitation to which it relates.

NOTE: Authority cited: Section 8456, Government Code. Reference: Sections 8445, 8450 and 15379.3, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).
4. Amendment of subsection (e)(3) filed 9–26–95; operative 10–26–95 (Register 95, No. 39).

§ 5474. Alliance/Office Scoring Criteria.

All eligible Proposals received by the deadline established in the Solicitation shall be scored by the Office or applicable Alliance using the below listed criteria. More points will be awarded for Proposals which better address the criteria.

(a) Job creation. The Project will result in immediate and measurable job creation for California. More points will be awarded to Proposals which provide credible evidence that the Project will result in the greatest number of jobs. Points awarded: 1 to 5.

(b) Clearly identified product line and market. More points will be awarded to Proposals which most clearly and concretely describe the Product, markets and strategy for attaining the identified market niche. Points awarded: 1 to 5.

(c) Credible Project Plan. More points will be awarded to those Proposals which include a credible plan for development of the Project showing a thorough understanding of and capacity for: production, capitalization, engineering, research and development. Points awarded: 1 to 5.

(d) Management Plan. More points will be awarded to those Proposals with concrete and credible discussion of the management of the Project and how successful management of the Project will result in commercial viability. Points awarded: 1 to 5.

(e) Management capacity. More points will be awarded to Proposals which identify Project personnel who have relevant experience in the area of Technology Commercialization, particularly in the area of Dual Use. Points awarded: 1 to 5.

(f) Relevancy of non–training Project to viable commercial market. More points will be awarded to Proposals which address a viable commercial market in geographic areas affected by Defense Conversion. Points awarded: 1 to 5.

(g) Training component that will upgrade workers' skills. More points will be awarded to Proposals which are concrete and realistic, clearly identifying the type or classification and number of workers and skills which will be upgraded and describe the training program in detail. Points awarded: 1 to 5.

(h) Diversity. The inclusion of Small Businesses as members of the Applicant, members of the board of directors of the Applicant and participants in the Project programs and activities. More points will be awarded to those Proposals including a wide variety and number of these businesses, in a variety of roles. Most points will be awarded to those Proposals including these businesses on the board of directors of the organization administering the Project. Points awarded: 1 to 3.

(i) Networking. Demonstrated links and networking with the California Manufacturing Excellence Program, the California Small Business Development Center Program, the California Supplier Improvement Program, business incubators, local education or business training institutions. More points will be awarded to Proposals which involve more of the above listed categories that add value to the Project. "Add value" is defined exclusively as being contractually involved in or providing direct services to, the Project. More points will also be awarded to Proposals that will network with Persons in both its Region and in other parts of California to increase the effectiveness and commercialization of the Project. Points awarded: 1 to 3.

(j) Cost Effectiveness. The Project is cost effective. More points will be awarded to those Proposals which utilize innovative methods to develop low cost solutions to Project problems or needs. Points awarded: 1 to 3.

(k) Cost Leverage. More points will be awarded to those Proposals which have more than the minimum cash Match contribution. The maximum points will be given for Match contributed in cash by Person(s) other than the Applicant. Points awarded: 1 to 5.

NOTE: Authority cited: Section 8456, Government Code. Reference: Sections 8445, 8450 and 15379.3, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).
4. Amendment of subsection (h) filed 9–26–95; operative 10–26–95 (Register 95, No. 39).

§ 5475. Review Panel Scoring Criteria.

All Proposals forwarded to the Office review panel pursuant to Section 5471(f) shall be reviewed for compliance with subsection (a) criteria and to determine whether it is complete. All Proposals in compliance with each of the subsection (a) criteria shall be scored pursuant to subsection (b).

(a) The Proposal complies with the following:

(1) It meets the Section 5472 eligibility requirements.

(2) The proposed use of Project funding is consistent with the requirements of the funding sources listed in the Proposal.

(3) There is no conflict of interest as defined by Government Code Sections 1090 or 87100 et seq.

(b) For the criteria listed below, more points will be awarded to Proposals which better meet the criteria.

(1) Job creation. The Project will result in immediate and measurable job creation for California. More points will be awarded to Proposals which provide credible evidence that the Project will result in the greatest number of jobs. Points awarded: 1 to 5.

(2) Clearly identified product line and market. More points will be awarded to Proposals which most clearly and concretely describe the Product markets and strategy for attaining the identified market niche. Points awarded: 1 to 5.

(3) Credible Project Plan. More points will be awarded to those Proposals which include a credible plan for development of the Project showing a thorough understanding of and capacity for: production, capitalization, engineering, research and development. Points awarded: 1 to 5.

(4) Management Plan. More points will be awarded to those Proposals with concrete and credible discussion of the management of the Project and how successful management of the Project will result in commercial viability. Points awarded: 1 to 5.

(5) Management capacity. More points will be awarded to Proposals which identify Project personnel who have relevant experience in the area of Technology Commercialization, particularly in the area of Dual Use. Points awarded: 1 to 5.

(6) Relevancy of non–training Project to viable commercial market. More points will be awarded to Proposals which address a viable commercial market in areas affected by Defense Conversion. Points awarded: 1 to 5.

(7) Training component that will upgrade workers' skills. More points will be awarded to Proposals which are concrete and realistic, clearly identifying the type or classification and number of workers and skills which will be upgraded and describe the training program in detail. Points awarded: 1 to 5.

(8) Diversity. The inclusion of Small Businesses as members of the Applicant, members of the board of directors of the Applicant and participants in the Project programs and activities. More points will be awarded to those Proposals including a wide variety and number of these businesses, in a variety of roles. Most points will be awarded to those Proposals including these businesses on the board of directors of the organization administering the Project. Points awarded: 1 to 3.

(9) Networking. Demonstrated links and networking with the California Manufacturing Excellence Program, the California Small Business Development Center Program, the California Supplier Improvement Program, business incubators, local education or business training institutions. More points will be awarded to Proposals which involve more of the above listed categories that add value to the Project. "Add value" is defined exclusively as being contractually involved in, or providing direct services to, the Project. More points will also be awarded to Proposals that will network with Persons in both its Region and in other parts of California to increase the effectiveness and commercialization of the Project. Points awarded: 1 to 3.

(10) Cost Effectiveness. The Project is cost effective. More points will be awarded to those Proposals which utilize innovative methods to develop low cost solutions to Project problems or needs. Points awarded: 1 to 3.

(11) Cost Leverage. More points will be awarded to those Proposals which have more than the minimum cash Match contribution. The maximum points will be given for Match contributed in cash by Person(s) other than the Applicant. Points awarded: 1 to 5.

(12) Extent to which Applicant's Project will benefit those areas of the state most severely affected by Defense Conversion. More points will be awarded Proposals that benefit area with the greatest severity of Defense Conversion impact. Points awarded: 1 to 5 points.

NOTE: Authority cited: Section 8456, Government Code. Reference: Sections 8450, 8452 and 8453, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).
4. Amendment of subsection (b)(8) filed 9–26–95; operative 10–26–95 (Register 95, No. 39).

§ 5476. Confidentiality.

Any Proposal with material designated by the Applicant as confidential shall comply with the procedures contained in Sections 5440 through 5443.

NOTE: Authority cited: Sections 6253(a) and 8456, Government Code. Reference: Sections 8445 and 15379.3, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).

§ 5477. Proposal Endorsement.

An Applicant shall be authorized to apply to the Office or Alliance for either funding or an endorsement. The Applicant applying for an endorsement shall follow the same procedure as an Applicant requesting funding. Applicants shall comply with Solicitation deadlines and all other requirements contained in the Solicitation and these regulations. The Council shall endorse any Proposal which would have been awarded a funding recommendation.

NOTE: Authority cited: Sections 6253(a) and 8456, Government Code. Reference: Section 8447, Government Code.

HISTORY

1. New section filed 3–7–94 as an emergency; operative 3–7–94 (Register 94, No. 10). A Certificate of Compliance must be transmitted to OAL by 9–6–94 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 7).
3. New section filed 4–10–95; operative 4–10–95 pursuant to Government Code section 11343.4(d) (Register 95, No. 15).

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Title 10. Investment

Chapter 7.72. Rural Investment Tax Exemption

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Chapter 7.72. Rural Investment Tax Exemption

§ 5480. Rural Investment Tax Exemption.

The California Infrastructure and Economic Development Bank (CIEDB) Board determines who is eligible to receive a Partial Exemption from sales or use taxes imposed on the gross receipts from the sale of and the storage, use or other consumption in this state of Eligible Tangible Personal Property and monitors eligible entities for compliance with the requirements of the Partial Exemption.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New chapter 7.72 (sections 5480–5480.8) and section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.1. Definitions.

The following definitions apply to this chapter:

(a) "Applicant" means a natural person or business entity submitting an Application.

(b) "Application" means a written request for an Eligibility Letter submitted to the CIEDB Board containing the information required in Section 5480.2.

(c) "Attainment Date" means the date an entity attains an Investment of one hundred fifty million dollars ($150,000,000) and fills 500 new Direct Jobs plus Supporting Jobs, including a minimum of 175 Direct Jobs, each as described in section 5480.1(i).

(d) "Authorized Applicant Representative" means the Chief Financial Officer, or equivalent, of the Applicant.

(e) "Certification Letter" means a letter written by an Authorized Applicant Representative to the CIEDB Board confirming that the Applicant has attained the required investment of one hundred fifty million ($150,000,000) and filled the 500 new Direct Jobs plus Supporting Jobs, each as described in Section 5480.1(i).

(f) "CIEDB Board" means the board of directors of the California Infrastructure and Economic Development Bank within the California Technology, Trade and Commerce Agency.

(g) "Commencement Date" means the first day of the Applicant's Fiscal Year containing January 1, 2001.

(h) "Direct Jobs" means FTE Employees in the County where the Eligible Facility is located.

(i) "Eligible Entity" means an Applicant that locates or expands an Eligible Facility and complies with all of the following:

(1) The Applicant makes an Investment of at least one hundred fifty million dollars ($150,000,000) in the county in which an Eligible Facility is located. In calculating the Investment, only Investments made between the Commencement Date and the date one year after the Partial Exemption Use Date (unless extended pursuant to an approved Extension Request) shall be included in the calculation;

(2) The Applicant maintains the Investment described in subsection (1) in the Qualified County for at least 24 months following the Attainment Date.

(3) The Applicant creates a minimum of 500 new Direct Jobs plus Supporting Jobs, including a minimum of 175 new Direct Jobs, in the county in which an Eligible Facility is located. In calculating the Direct Jobs and Supporting Jobs, only those Direct Jobs and Supporting Jobs filled between the Commencement Date and the date one year after the Partial Exemption Use Date (unless extended pursuant to an approved Extension Request) shall be included in the calculation. "New" as used in this section means an FTE Employee hired into a position not previously held by another employee of the Applicant.

(4) The Applicant maintains the 500 new Direct Jobs plus Supporting Jobs described in subsection (3) in the Qualified County for at least 24 months following the Attainment Date.

(j) "Eligible Facility" means the physical location within a Qualified County owned or leased by the Eligible Entity.

(k) "Eligibility Letter" means the written notification from the CIEDB Board to the Applicant required pursuant to Revenue and Taxation Code Section 6378.1(g) stating that the Applicant is eligible to request a Partial Exemption.

(l) "Eligible Tangible Personal Property" means 'Tangible Personal Property' as defined in California Code of Regulations, Title 18, section 1525.7.

(m) "Exemption Allocation Letter" means the written notification from the CIEDB Board stating that the Applicant has received a specified amount of Partial Exemption for the indicated year.

(n) "Extension Request" means a written request by an Applicant to extend by up to 12 months the Attainment Date.

(o) "FTE Employee" means one or more employees collectively employed by the Applicant for 1,750 hours per year and not moved, transferred, or displaced from other California locations owned or operated by the Applicant or related entity. As used in this subsection, "related entity" means an entity that the Applicant owns 51% or more of or another entity that owns 51% or more of the Applicant.

(p) "Intent of Revocation Letter" means written notification from the CIEDB Board to the Board of Equalization and the Applicant stating that the Applicant is no longer an Eligible Entity. The letter shall include the effective date of the revocation, which shall be the date the CIEDB Board determines that the Applicant failed to meet the Eligible Entity requirements in Section 5480.1(i).

(q) "Investment" means money spent by the Applicant in the county where the Eligible Facility is located for the following: Construction, renovation, and acquisition of all lands, structures, real property, rights, rights–of–way, franchises, licenses, easements, and interests acquired or used in the county, including:

(1) The cost of demolishing or removing any buildings or structures;

(2) The cost of all machinery and equipment located in the county; and

(3) The cost of architectural, engineering, and legal services, plans, specifications, estimates, and other expenses necessary or incidental to the construction or acquisition of a building or structure in the county.

(r) "NAICS" means North American Industrial Classification System code published by the United States Office of Management and Budget, 1997 edition.

(s) "Partial Exemption" means an exemption from only those taxes imposed by Sections 6051, 6051.3, 6201, and 6201.3 of the Revenue and Taxation Code on the gross receipts from the sale in this state of, and the storage, use or other consumption in this state of Eligible Tangible Personal Property purchased by an Eligible Entity.

(t) "Partial Exemption Use Date" means the earliest date on which the Eligible Entity purchases the Eligible Tangible Personal Property upon which it applies any Partial Exemption.

(u) "Qualified County" means a California county with an average annual unemployment rate of five percentage points or more above the statewide average for the most recent calendar year as determined by the State of California, Employment Development Department.

(v) "Request" means a request for a Partial Exemption allocation.

(w) "SIC" means the Standard Industrial Classification Manual published by the United States Office of Management and Budget, 1987.

(x) "Supporting Jobs" means the estimated number of full time equivalent employees created in the Eligible County determined by use of the United States Department of Commerce, Bureau of Economic Analysis' Regional Input–Output Multipliers RIMS II for the county.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.2. Eligible Entity Application.

(a) A complete Application consists of a written request containing all of the following items:

(1) Name of Applicant;

(2) Address of Eligible Facility;

(3) Primary classification code from the SIC or NAICS for the Eligible Facility;

(4) Applicant contact person name, title, address, phone number, fax number and email address;

(5) Date the Application is signed;

(6) Signature of an Authorized Applicant Representative;

(7) The following information relating to Direct Jobs:

(A) For FTE Employees hired on or before the date of the Application:

1. The job title of each employee;

2. The date of hire of each employee;

3. The primary job location for each employee. As used in this subsection "primary job location" means the location where the employee performs a minimum of 50% of their work duties;

4. The hours worked by each employee in the last year. If the employee has been employed less than one year and the position was in existence prior to the hiring of the employee, include the hours allocated to this position prior to the hiring of this employee. If the position has existed for less than a year the number of hours for the position when extrapolating existing hours to an annualized basis, e.,g. 600 hours for 6 months is a 1,200 hour annualized position. In no case shall one employee, or one job position, if more than one person held the same job position (e.g. one employee left the firm and was replaced with another employee) account for more than 1,750 hours annually; and

5. A certification by the Authorized Applicant Representative that as of the date the Application is signed each employee listed is still working for the Applicant at approximately the FTE Employee hours listed in the Application, their primary job location is in the county where the Eligible Facility is located, and the Direct Jobs and Supporting Jobs will be maintained for at least 24 months following the Attainment Date.

(B) For FTE Employees to be hired after the date of the Application;

1. The job title of each employee that will be hired;

2. The estimated date of hire of each employee;

3. An estimate of annual hours of employment for that employee; and

4. A certification that the Applicant has a good faith intention to hire employees for the job positions as listed, approximately when listed, agrees and understands that each employee must be primarily employed in the county where the Eligible Facility is located and must be maintained for at least 24 months following the Attainment Date.

(8) Detailed listing of the items making up the Investment including the following information:

(A) For item(s) already purchased:

1. Date of purchase;

2. Amount and proof of purchase, e.,g. invoice;

3. Description of item and use; and

4. A certification that as of the date the Application is signed this portion of the Investment is still owned by the Applicant, located in the county where the Eligible Facility is located, and that the Investment will be owned by the Applicant and maintained in the county for at least 24 months after the Attainment Date.

(B) For item(s) to be purchased in the future;

1. Estimated date of purchase;

2. Estimated amount of purchase and written basis for the estimate, e.g. invoices, purchase orders or vendor materials;

3. Description of item and use; and

4. A certification that the Investment will be made by the Applicant and located in the county where the Eligible Facility is located, and that the Investment will be owned by the Applicant and maintained in the county for at least 24 months after the Attainment Date.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.3. Partial Exemption Allocation Request.

(a) A complete Request, when submitted with an Eligible Entity Application, shall consist of the following:

(1) The amount of Partial Exemption requested for the current year;

(2) The Partial Exemption Use Date, if known;

(3) A certification that the Request is based on a good faith estimate by Applicant to fully utilize the amount of the Request; and

(4) A certification that includes the following language: "I hereby certify that [name of Eligible Entity] will [or has] purchased during calendar year 20__ tangible personal property meeting the requirements of the California Code of Regulations, title 18, section 1525.7 in an amount that would entitle [name of Eligible Entity] to a partial exemption of [amount], pursuant to Revenue and Taxation Code section 6378.1;"

(b) A complete Request, when submitted subsequent to the Eligible Entity Application, shall consist of a written document signed and dated by an Authorized Applicant Representative and containing all of the following information:

(1) Name of Applicant;

(2) Address of Eligible Facility;

(3) Primary classification code from the SIC or NAICS for the Eligible Facility;

(4) Applicant contact person name, title, address, phone number, fax number and email address;

(5) The amount of Partial Exemption requested for the current year;

(6) The Partial Exemption Use Date, if known;

(7) A certification that the Request is based on a good faith estimate by Applicant to fully utilize the amount of the Request;

(8) A certification that includes the following language: "I hereby certify that [name of Eligible Entity] will [or has] purchased during calendar year ____ tangible personal property meeting the requirements of the California Code of Regulations, title 18, section 1525.7 in an amount that would entitle [name of Eligible Entity] to a partial exemption of [amount], pursuant to Revenue and Taxation Code section 6378.1;" and

(9) For Applicants that have already received a Eligibility Letter:

(A) A copy of the Eligibility Letter.

(B) A certification by an Authorized Applicant Representative that the Applicant is on schedule to meet the Investment, and filling of new Direct Jobs plus Supporting Jobs, each as required by section 5480.1(i).

(C) A copy of any Certification Letter that was submitted as described in Section 5480.7.

(D) A Copy of Extension Requests granted pursuant to Section 5480.6, if applicable.

(E) A copy of any previously received Exemption Allocation Letter(s); and either

1. The Partial Exemption Use Date; or

2. Written authorization for the CIEDB Staff to obtain confirmation from the Board of Equalization that the Applicant has not used the Partial Exemption.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.4. Application and Request Process.

(a) The CIEDB Board shall establish the date of the CIEDB Board meeting for Applications and Requests to be considered at the beginning of each calendar year. CIEDB shall provide notice of this meeting via the mail to individuals on its Interested Parties List, post on the CIEDB Website, and file an advertisement in the California Regulatory Notice Register at least 30 days prior to the application deadline. Any person may be placed on the Interested Parties List by notifying the CIEDB Board.

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(b) The deadline for all Applications and Requests shall be 60 days prior to the established CIEDB Board meeting. All Applications and Requests must be postmarked at least 60 calendar days prior to the CIEDB Board meeting designated in subsection (a).

(c) If the Application or Request is either incomplete or does not document intent to meet the requirements of an Eligible Entity, the CIEDB Board shall send a written notice of deficiency not later than 15 days from the date the Application is received by the CIEDB Board. The notice of deficiency shall state what items in the Application or Request must be corrected to be complete and/or document intent to be an Eligible Entity. The Applicant will have ten calendar days to submit to the CIEDB Board written correction to the deficiency.

(d) An Application shall be considered complete if it is postmarked by the deadline provided in subsection (b), complies with Section 5480.2 and if applicable, complies with the provisions in subsection (c) of this section. A Request shall be considered complete if it is postmarked by the deadline provided in subsection (b), complies with Section 5480.3, and if applicable, complies with the provisions in subsection (c) of this section.

(e) CIEDB Board staff shall recommend approval of all complete Applications and Requests, and recommend disapproval of incomplete Applications or Requests unless all of the deficiencies are corrected within the timeframe specified in subsection (c).

(f) The CIEDB Board shall adopt a resolution for each applicant approved as an Eligible Entity and execute an Eligibility Letter. The Eligibility Letter shall remain valid until and unless the CIEDB Board issues an Intent of Revocation Letter.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.5. Partial Exemption Allocation.

(a) At the CIEDB Board meeting established in Section 5480.4(a), the CIEDB Board shall allocate the five million dollars ($5,000,000) aggregate maximum Partial Exemption for the then current calendar year to Eligible Entities requesting a Partial Exemption including those Eligible Entities authorized at the same meeting.

(b) No Eligible Entity shall be authorized to request an amount in excess of five million dollars ($5,000,000) per year.

(c) If the Partial Exemption amounts requested by all complete Requests exceeds five million dollars ($5,000,000), the amount available for the allocation to each Eligible Entity shall be a percentage based upon the amount requested by each entity in comparison to the other requests. A formula shall be used where the numerator is the dollar amount requested by a single complete Eligible Entity's Request and the denominator is the total dollar amount of all complete Eligible Entity Requests.

(d) Eligible Entities seeking a Partial Exemption for the 2001 calendar year will be considered through the same allocation process as described in Section 5480.3 during the 2002 calendar year meeting established in section 5480.4(a). Requests that are approved by the CIEDB Board will receive an Exemption Allocation Letter for the 2001 calendar year. The Eligible Entity will present this letter to the Board of Equalization for direction in processing a refund.

(e) CIEDB Board will issue an Exemption Allocation Letter to each Eligible Entity indicating the amount of the Partial Exemption that is awarded to the Eligible Entity for the current year as determined by subsection (c).

(f) The Eligible Entity awarded the Exemption Allocation Letter shall submit the letter to the Board of Equalization as provided in California Code of Regulations, Title 18, Section 1525.7(c)(1).

(g) The Eligible Entity shall notify the CIEDB Board of the Partial Exemption Use Date.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1. Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.6. Attainment Date Extension Request.

(a) An Eligible Entity that determines it will not attain the required Investment of one hundred fifty million dollars ($150,000,000) and the hiring of 500 new Direct Jobs plus Supporting Jobs, each as required in section 5480.1(i) within one year of Partial Exemption Use Date shall be authorized to submit an Extension Request to the CIEDB Board. An Extension Request must be postmarked no later than one year following the Partial Exemption Use Date.

(b) An Eligible Entity may only submit one Extension Request.

(c) The complete Extension Request shall consist of a written request signed and dated by an Authorized Applicant Representative containing all the following information:

(1) A copy of the original Application;

(2) A copy of the Eligibility Letter;

(3) The Partial Exemption Use Date;

(4) The amount of Investment attained and number of Direct Jobs created to date;

(5) A detailed description of the reasons for not being able to attain Investment and filling 500 new Direct Jobs plus Supporting Jobs, each as required by section 5480.1(i), within one year of the Partial Exemption Use Date; and

(6) A certification that the Applicant has a good faith belief that the Applicant will fill 500 new Direct Jobs plus Supporting Jobs and attain the Investment of one hundred fifty million dollars ($150,000,000), each as required in section 5480.1(i), within two (2) years of the Partial Exemption Use Date, and describing the basis for the belief.

(d) The CIEDB shall include on the agenda for a CIEDB Board meeting scheduled within 60 calendar days following the receipt of a complete Extension Request consideration of the Extension Request and notify the Applicant of the meeting not later than 20 calendar days prior to the meeting

(e) The CIEDB staff shall recommend approval of the Extension Request upon a finding that the Extension Request evidenced compliance with both of the following:

(1) Extraordinary circumstances beyond the control of the Applicant exist that have prevented the attainment of the one hundred fifty million dollar ($150,000,000) Investment and filling of the 500 new Direct Jobs plus Supporting Jobs; and

(2) The extraordinary circumstances will not prevent the one hundred fifty million dollar ($150,000,000) Investment and filling of the 500 new Direct Jobs plus Supporting Jobs from being attained within two years of the Partial Exemption Use Date.

(f) As used in subsection (e), "Extraordinary Circumstances" means the delay is due to circumstances beyond the Applicant's control.

(g) The CIEDB Board will issue a written notification to the Eligible Entity indicating the results of the Extension Request.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.7. Certification Letter Process for Notifying CIEDB Board of Investment and Job Creation Attainment.

(a) An Eligible Entity that has attained, within one year of the Partial Exemption Use Date (unless extended pursuant to an approved Extension Request) the minimum Investment of one hundred fifty million dollars ($150,000,000) and the filling of 500 new Direct Jobs plus Supporting Jobs, each as required in section 5480.1(i), shall submit a Certification Letter to the CIEDB Board to be postmarked within 30 calendar days following the Attainment Date.

(b) The Certification Letter, signed by the Authorized Applicant Representative, shall be postmarked not later than 30 calendar days following the Attainment Date and shall include the following:

(1) The name of the Applicant;

(2) The name, address, phone number, fax number and email address of the Authorized Applicant Representative;

(3) The Partial Exemption Use Date; and

(4) Attach the Exemption Allocation Letter.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

§ 5480.8. Monitoring Process.

(a) The CIEDB Board shall determine if Eligible Entities utilizing the Partial Exemption awarded by the CIEDB Board have met all of the following requirements:

(1) Submitted a Certification Letter documenting both the Investments made and 500 new Direct Jobs plus Supporting Jobs within one year of the Partial Exemption Use Date (unless extended pursuant to an approved Extension Request); and

(2) The Eligible Entity has attained and maintained the Investment, and 500 new Direct Jobs plus Supporting Jobs.

(b) If CIEDB staff determines that any Eligible Entity has not met the requirement in subsection (a) it will mail to the Eligible Entity an Intent of Revocation Letter

(c) Eligible Entities that receive an Intent of Revocation Letter shall be authorized to request an opportunity to be heard in front of the CIEDB Board to contest the Intent of Revocation Letter. Any such request must be made in writing to the CIEDB Board and postmarked not later than 15 calendar days following mailing of the Intent of Revocation Letter.

(d) The CIEDB Board shall agenda all Intent of Revocation Letters at the next regularly scheduled Board meeting, held on or after 30 days from the date of the mailing of an Intent of Revocation Letter. Upon adoption of the Intent of Revocation Letter, the CIEDB Board shall mail the Intent of Revocation Letter to the Board of Equalization and to the Eligible Entity within 7 calendar days of its adoption.

NOTE: Authority cited: Section 11152, Government Code; and Section 6378.1, Revenue and Taxation Code. Reference: Section 6378.1, Revenue and Taxation Code.

HISTORY

1. New section filed 8–15–2002; operative 9–14–2002 (Register 2002, No. 33).

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Chapter 7.8. Enterprise Zone Designation Process

HISTORY

1. Change without regulatory effect moving title 10, chapter 7.8, articles 1–10 to title 25, division 1, chapter 7, subchapter 21, articles 3–13 filed 7–19–2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 29). For prior history of sections 5640–5640.22, see Register 2000, No. 20.

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Chapter 7.85. Local Area Military Base Recovery Area Designation

§ 5750.0. Definitions.

The following definitions shall apply to the regulations contained in this chapter, in addition to the definitions contained in Government Code section 7107:

(a) "Act" means the Local Military Base Recovery Area Act, Chapter 1216, Statutes of 1993.

(b) "Applicant" means a governing body, as defined in the Act, who has petitioned to have a geographical area within its jurisdiction designated as a Local Military Base Recovery Area (LAMBRA).

(c) "Application" means a written petition requesting the designation of a proposed application area as a LAMBRA which meets the content and format requirements of section 5750.3 of this chapter.

(d) "Application area" means the geographical area meeting the requirements and criteria of Government Code sections 7110 and 7111.

(e) "Preliminary application" means a written petition requesting the Agency's evaluation of the applicant's eligibility to file an application which contains the information required by section 5750.2 of this chapter.

(f) "Conditional designation" means designation by the Agency of an application area as a LAMBRA, subject to the applicant's completion of conditions necessary for final designation specified in Government Code sections 7113(b) and (c), and section 5750.6 of this chapter.

(g) "Technical deficiency" shall include but not be limited to a failure to submit one or more of the required elements of an application, missing pages, patent ambiguities or other issues of clarity, and a failure to submit an element of the application in the required form such as resolution, ordinance, or certification.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7105, 7106, 7107, 7110, 7111 and 7113, Government Code.

HISTORY

1. New chapter 7.85 (sections 5750.0–5750.9) and section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New chapter 7.85 (sections 57500.0–5750.9) and section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Amendment of section and NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.1. Notification — LAMBRA Application Process.

(a) The Agency shall notify all persons and entities who have requested information on the designation of a LAMBRA of the required contents of preliminary applications, applications, the criteria to be employed by the Agency in designating a LAMBRA, including the system of scoring applications, and final due dates for the submission of preliminary applications and applications to the Agency. The Agency shall additionally prescribe the date upon which the screening of applications for technical compliance and clarity will be accomplished. Any technical deficiencies found in an application shall be communicated to the applicant, who shall have a period of two weeks from the date of mailing of the notice of deficiency to cure the defects in the application.

(b) The Agency shall provide assistance to applicants in completing applications both prior to initial submission and during the period permitted to correct deficiencies in submitted applications.

(c) Applications not corrected within the time period allowed shall be disqualified from further consideration for designation as a LAMBRA, except where new submissions and resubmissions are permitted under section 5750.6 of this chapter.

(d) Notwithstanding the foregoing, the Agency reserves the right to contact applicants at any time, including during scoring, to obtain clarification of submitted information, but not to obtain additional information.

NOTE: Authority cited: Sections 7107 and 7113, Government Code. Reference: Sections 7107 and 7110, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Amendment of section and NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.2. Preliminary Application – Eligibility for Application.

A preliminary application shall establish the eligibility for designation of the application area and shall include the following information:

(a) A statement of the applicant's organizational status and documentation of its authority to represent the application area in implementing base reuse strategies.

(b) A description of the geographic area, using definitive boundaries, proposed for designation as a LAMBRA.

(c) A copy of the reuse plan approved by applicant for the application area.

(d) A copy of an initial study and notice of preparation prepared for projects proposed within the application area pursuant to the California Environmental Quality Act (Public Resources Code section 21000 et seq.) and associated guidelines (14 C.C.R. sections 15000 et seq.).

NOTE: Effective January 1, 1995, applicants may utilize an environmental impact statement (EIS), if one has been prepared for the reuse plan under 42 U.S.C. sections 4321 et seq., as a draft environmental impact report (EIR) so long as a notice of preparation is prepared which includes a description of the reuse plan, a copy of the EIS, a statement that the applicant intends to use the EIS as a draft EIR; additionally, the notice of preparation is to solicit comments as to whether the EIS contains sufficient information to serve as a draft EIR, and what additional information must be added to comply with the California Environmental Quality Act. A copy of a notice of preparation complying with the provisions of the section cited below will be accepted in lieu of the requirements of this subdivision after January 1, 1995. (Public Resources Code section 21083.8, as effective January 1, 1995; Stats. 1994, Ch. 842).

NOTE: See also Public Resources Code section 21157 (Stats. 1994, Ch. 1294) as effective October 4, 1994, regarding the use of master environmental impact reports.

(e) A letter of intent to apply for LAMBRA designation should all eligibility requirements be met as shown by the preliminary application.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7110 and 7111, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).

3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Amendment of section and NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.3. Application for Conditional Designation.

Applicants establishing eligibility through their preliminary application shall be invited to submit an application for conditional designation which shall contain the following:

(a) A certified copy of the ordinance or resolution by which the applicant has determined to propose the area for designation as a LAMBRA.

(b) A copy of the reuse plan approved for the application area, including amendments adopted and approved subsequent to the time the preliminary application was filed, and:

(1) A copy of the resolution whereby applicant has committed to the preparation of a program environmental impact report on the reuse plan pursuant to the California Environmental Quality Act (Public Resources Code sections 21000 et seq.) and associated guidelines (14 C.C.R. sections 15000 et seq.).

(2) A citation to the federal act which has scheduled the application area for downsizing or closure.

(c) A description of the application area in narrative and illustrative terms; and land use plans and zoning applicable to the application area together with land use designations and zoning on adjacent parcels.

(d) A copy of a plan integrating hazardous waste management facilities with existing and proposed development in the application area, if any. If applicant has determined hazardous waste management facilities are critically needed, applicant may submit a statement in support of such a finding.

(e) A certified copy of findings by the applicant that:

(1) The application area meets the requirements of Government Code section 7111; and

(2) LAMBRA designation is necessary to attract private sector investment to the application area.

(f) A copy of Applicant's economic development plan, prepared pursuant to section 5750.5.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7110 and 7111, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Amendment of section and NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.4. Evaluation Criteria and Scoring.

(a) Applications determined to be complete upon submittal or after the expiration of the correction period permitted by section 5750.1 shall be sorted those five regions established in Government Code section 7107, subdivisions (i) through (m), inclusive. Proposals for designation of a LAMBRA shall only compete for designation against other proposals within a region. Only one LAMBRA may be designated within a region. Competing applicants shall be scored on the basis of their economic development plan, which shall contain the information and data prescribed in section 5750.5, below. An additional 35 bonus points shall be awarded to applicants who have submitted a hazardous waste management plan, which, as determined by the Agency, meets a critical need for such a facility.

(b) The Agency shall evaluate and numerically grade each economic development plan based upon the categories and the corresponding point values set forth below. All points awarded shall be accumulated and the applicant within each region achieving the numerically highest point value, so long as such total value equals or exceeds sixty percent of the total points possible, shall be designated as a conditional designee. Bonus points awarded to an application in subdivision (a), above, shall not be included in the applicant's total score for meeting the sixty percent minimum requirement, and shall not be included in calculating the total number of points possible.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7107, 7110 and 7113.5, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Repealer and new section and amendment of NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.5. Economic Development Plan.

Each economic development plan shall contain the information and data required by this section.

(a) Marketing (0 – 225 Points). A detailed marketing plan for the application area which shall include the following:

(1) A statement and explanation of the specific marketing goals for the application area and the course(s) of action to be taken to achieve the specified goals.

(2) A detailed description of plans to recruit new business into the application area, including the names of industries targeted for recruitment.

(3) Identification and detailed description of the local economic development corporation or similar organization and its role in attracting industries to the application area.

(4) A detailed description of the sales plan for on–site visits to businesses.

(5) A detailed description of advertising and promotional strategy, including a media analysis and samples of existing advertising and promotional materials.

(6) A detailed analysis of the staff, organization structure, and budgets to be committed to the marketing plan(s) by all involved organizations.

(7) Specific examples of successful efforts by the corporations or organizations identified in subsection (3), above, to attract or retain businesses.

(8) A list of all commercial real estate brokers who will handle real estate transactions within the application area.

(9) Any other relevant items pertaining to the applicant's plans for marketing the application area.

(b) Property Characteristics (0 – 125 Points).

(1) The total number of all buildings on the site, together with the square footage, physical description and prior (or current) use of each structure.

(2) An analysis of the likelihood that each structure will meet all local and state building, fire, and seismic codes, and any other codes necessary to operate a business.

(3) An analysis of the most appropriate, economical, functional reuse for each existing structure.

(4) The total number of acres of vacant, improved land.

(5) The total number of acres of vacant, unimproved land.

(6) A description and analysis of the infrastructure within the application area, including peak delivery capability and peak capacity for water supply, storm drainage, sewer and waste treatment, streets and street lighting, natural gas and electricity; and any plans to expand or improve services including associated costs, proposed financing and timetable for completion.

(7) Any other relevant information concerning the property, structures, or infrastructure.

(c) Job Development (1 – 150 Points) Include a detailed explanation of the plan to identify, train and place unemployed and under–employed into jobs created through marketing of the application area, including the following:

(1) A list containing the names and addresses of all administrative agencies and/or contractors who will provide intake and/or job development services in the application area under the Job Training Partnership Act (JTPA), (29 U.S.C. sections 1501 et seq.), Targeted Job Tax Credit (TJTC), (26 U.S.C. section 51) and the Greater Avenues for Independence (GAIN) (Welfare and Institutions Code section 11320 et seq.).

(2) A detailed explanation of the specific contributions that each administrative agency and/or contractor shall make for the implementation of the job development plan.

(3) A detailed explanation of how the recipients of JTPA, GAIN, and TJTC services will be placed in LAMBRA jobs. The applicant shall include a detailed explanation of the coordination efforts between job development agencies and contractors.

(4) Data which show the track record of job placements by each participating agency and or contractor for the two years immediately preceding the date of the application.

(5) A detailed organization chart showing all staff persons providing job development management and services for each agency and/or contractor identified in the job development portion of the economic development plan.

(6) Any other indicators of the applicant's job development plans for the application area.

(d) Local Incentives (0 – 200 Points) Include a list and detailed explanation of incentives which will be used to attract private sector investors to the application area which may include:

(1) The elimination or reduction of fees imposed for development, building, licensing, use permits and other necessary approvals and permits.

(2) Fast track or streamlined time frames for project and permit approval within the applicant's jurisdiction for application area projects.

(3) Reduction or postponement of fees and other charges for services, utilities, and other ongoing liabilities.

(4) The elimination or reduction of business license taxes and utility user taxes.

(5) Technical assistance programs to aid private sector investors in obtaining necessary permits and other approvals.

(6) Any other incentives proposed and adopted by applicant such as one–stop permit processing under a memorandum of agreement with the Secretary for Environmental Protection pursuant to Chapter 3.2 (commencing with section 15378.5) of Part 6.7 of Division 3 of Title 2 of the Government Code (Stats. 1994, Ch. 34).

(e) Financing Programs (0 – 150 Points). List and provide a detailed explanation of all financing available to private sector investors in the application area, including:

(1) Identification of all agencies, organizations, and firms that will provide financial assistance to businesses in the application area.

(2) An explanation of the types of services to be offered and data showing companies served by the agencies, organizations and firms listed under (1), above, during the three year period immediately preceeding the date of the application.

(3) Identification of all financial institutions that have expressed an interest in making business loans to companies locating in the application area and all financial institutions currently making loans guaranteed by the Small Business Administration.

(4) A detailed explanation of the loan programs currently offered by the applicant with data on the result of those programs for the three year period immediately preceding the date of the application.

(5) Planned targeting of federal and/or state grant or loan moneys and the uses for those moneys within the application area.

(6) Any other details and information related to financing programs or incentives to be offered by the applicant.

(f) Unemployment (0 – 100 Points). Provide unemployment levels for the political area under applicant's jurisdiction, including:

(1) The present unemployment rate and the historical unemployment rate for three years preceding the date of application for the area within the political boundaries of applicant's jurisdiction.

(2) The ratio of civilian and military jobs lost to base closure to the total number of jobs in the area together with supporting documentation.

(3) The number of workers available for targeted jobs as specified within the applicant's marketing plan.

(g) Consistency (0 – 25 points)

The economic development plan shall be compared with the reuse plan and points awarded on the basis of consistency between the two plans.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Section 7110, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Amendment of section and NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.6. Final Designation.

(a) If there is no application within a region which achieves at least sixty percent of the total possible number of points, excluding points awarded for a hazardous waste management facility, then the agency shall not award a conditional designation for that region, but shall notify each applicant of the deficiencies in their application, allowing a time which shall be specified by the Agency for revision and resubmission of the application. The Agency shall also accept new applications for designation within that region up to the time set for resubmission of revised applications. The agency shall score or re–score the applications in accordance with these regulations. If after scoring the new and resubmitted

applications, there are none achieving sixty percent or more of the total possible number of points, no LAMBRA shall be designated in that region.

(b) If two or more applicants within a region achieve the same overall score, the tied applicant with the highest score in the "local incentives" element of the application shall be selected as the conditional designee for the region.

(c) A conditional designee shall, as lead agency, prepare or cause to be prepared a draft environmental impact report pursuant to the California Environmental Quality Act (Public Resources Code sections 21000 et seq.) and guidelines promulgated thereunder (14 C.C.R. sections 15000 et seq.) for any and all projects proposed within the application area. If the project(s) are subject to the National Environmental Policy Act (42 U.S.C. sections 4321 et seq.) the applicant shall, to the greatest extent feasible, prepare a joint environmental impact report/environmental impact statement.

NOTE: See Notes following section 5750.2(d) of this chapter.

(d) Prior to final designation, a conditional designee shall submit to the Agency a final application containing a detailed description of the annual budget(s), staff and organization for administration of the application area, including:

(1) The conditional designee's annual line item budget and source of funding that will be committed to the administration of the proposed LAMBRA area.

(2) The annual budgets (dollars) for each agency, or organization, other than the final applicant, which has been identified as providing marketing, job development, and other aspects of the final applicant's economic development plan.

(3) The name(s) of the person(s) who will act as the LAMBRA coordinator(s) and administer the LAMBRA on a full time basis.

(4) An organization chart that shows all persons and organizations involved in all aspects of the proposed LAMBRA, including marketing, job development, financing and administration, together with their reporting relationship to the LAMBRA coordinator. The organization chart shall show people by name and job title.

(5) A certified copy of the resolution or ordinance adopted by the conditional designee certifying the final environmental impact report and approving the project.

(e) Except as provided in subdivision (f), below, if a conditional designee fails to fulfill the above conditions for final designation within a period of ninety days following notice of conditional designation, then the conditional designation shall be automatically revoked without further notice from the Agency. The agency shall then accept new and resubmitted applications for the region in the same manner as if no applicant met the minimum score requirement as in subdivision (a) of this section.

(f) Where a joint environmental impact report/environmental impact statement has been prepared for the project and has not been finally approved by the United States Military Department, and the conditional designee cannot fulfill the conditions for final designation because that approval has not occurred, then the Agency may extend the period specified in subdivision (e), above, for the sole purpose of allowing the conditional designee to certify the final environmental impact report/environmental impact statement. All other conditions for final designation must be completed within the period specified in subdivision (e), above.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7113 and 7113.5, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Amendment of subsection (e) and new subsection (f) filed 6–3–96 as an emergency pursuant to Government Code section 7114; operative 6–3–96 (Register 96, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–2–96 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 6–3–96 order transmitted to OAL 10–18–96 and filed 12–4–96 (Register 96, No. 49).
8. Amendment of section and NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.
9. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.7. Effective Date of LAMBRA Designation.

None of the benefits or responsibilities of designation as a LAMBRA shall become effective until final designation, and upon such designation shall exist for a period of eight years subject to the time limitations of sections 17053.45, 17053.46, 17268, 17276.2, 23645, 23646, 24356.8, and 24416.2 of the Revenue and Tax Code, unless revoked pursuant to Section 5750.8 of this chapter.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7107 and 7114, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).

§ 5750.8. Monitoring.

(a) If the Agency determines that a designated LAMBRA is not complying with the terms of the approved application for designation, the Agency shall provide written notice identifying the program deficiencies. The LAMBRA shall have six months to correct the deficiencies.

(b) If a LAMBRA fails to correct identified deficiencies within the time period allotted, the LAMBRA designation shall be revoked until the identified deficiencies are corrected.

(c) Companies located within an area for which the LAMBRA designation has been revoked shall not be penalized during any period of revocation and shall continue to receive the benefit of incentives provided by the LAMBRA program; however companies commencing operations during the revocation period shall not be eligible for incentive benefits until the LAMBRA designation is restored by the Agency.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Section 7116, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
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5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).
6. Repealer and new subsection (a), amendment of subsection (b) and amendment of NOTE filed 5–31–2000 as an emergency; operative 5–31–2000 (Register 2000, No. 22). Pursuant to Government Code section 7114(c), a Certificate of Compliance must be transmitted to OAL by 11–27–2000 or emergency language will be repealed by operation of law on the following day.

7. Reinstatement of section and NOTE as they existed prior to 5–31–2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2003, No. 10).

§ 5750.9. Finality of Agency Decisions.

(a) Agency decisions shall be final and no appeal is available to the Agency. An applicant shall not petition the Agency for rehearing nor request a written explanation of any Agency decision.

(b) Applicants shall have the right to request a meeting with the Agency's LAMBRA Program Manager, at which time the Agency's LAMBRA Program Manager shall explain the reasons for any of the Agency's decisions pursuant to this chapter.

NOTE: Authority cited: Sections 7107 and 7114, Government Code. Reference: Sections 7107 and 7114, Government Code.

HISTORY

1. New section filed 11–8–94 as an emergency pursuant to Government Code section 7114(d); operative 11–8–94 (Register 94, No. 46). A Certificate of Compliance must be transmitted to OAL by 5–7–95 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1(g) (Register 95, No. 21).
3. Editorial correction of HISTORY 1 (Register 95, No. 23).
4. New section filed 6–7–95 as an emergency pursuant to Government Code section 7114(d); operative 6–7–95 (Register 95, No. 23). A Certificate of Compliance must be transmitted to OAL by 12–4–95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 6–7–95 order transmitted to OAL 12–12–95 and filed 1–24–96 (Register 96, No. 4).

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Title 10. Investment

Chapter 7.95. Trade and Commerce Agency: Repair Underground Storage Tank Loan Program

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Chapter 7.95. Trade and Commerce Agency: Repair Underground Storage Tank Loan Program

§ 5900. Definitions.

The following definitions shall govern construction of this chapter:

(a) "Act" means chapter 8.5 (commencing with section 15399.10) of part 6.7 of division 3 of title 2 of the Government Code.

(b) "Applicant" means an entity that owns or operates a Project Tank and is applying for a Loan or a Grant.

(c) "Application" means the information contained in sections 5904 or 5904.1 which an Applicant must provide to the Office when seeking a Loan or a Grant.

(d) "Borrower" means an Applicant whose Application for a Loan has been approved and who has executed a Loan Agreement.

(e) "Corrective Action" means all actions taken as described in Health & Safety Code section 25299.14 to correct an unauthorized release, including: evaluation and investigation of the unauthorized release, initial corrective action measures, clean-up of the release, any actions necessary to investigate and remedy any residual effects remaining after the initial corrective action, and post clean-up monitoring.

(f) "Environmental Audit" means an investigation into the Applicant's operations and compliance with federal, state and local environmental laws, regulations and rulings, which would indicate whether the facility is, or is likely to become, contaminated.

(g) "Financial Responsibility" means the state and federal requirements, established in accordance with subpart H, of part 280 of subchapter I of chapter I of title 40 of the Code of Federal Regulations, commencing with section 280.92, providing that a Tank owner or operator must demonstrate the ability to pay for Corrective Action and third-party liability arising from owning or operating a Tank.

(h) "Grant" means an award of Remove Underground Storage Tank funding pursuant to this chapter which need not be repaid.

(i) "Grant Agreement" means a written agreement for a Grant made in accordance with this regulation.

(j) "Local Agency" means the department, office or other agency within a county, or a city, designated pursuant to Health and Safety Code section 25283 to implement chapter 6.7 of division 20 of the Health and Safety Code.

(k) "Loan" means a lending of funds pursuant to a Loan Agreement.

(*l*) "Loan Agreement" means a written agreement for a Loan made in accordance with this regulation.

(m) "Office" means the Office of Small Business within the Trade and Commerce Agency.

(n) "Permit" means a permit to own or operate a Tank as required pursuant to section 25284 of the Health and Safety Code.

(o) "Petroleum" means crude oil, or any fraction thereof, which is liquid at standard conditions of temperature and pressure, which means at 60 degrees Fahrenheit and 14.7 pounds per square inch absolute.

(p) "Project" means the work an Applicant proposes to conduct on a Tank by either removing, replacing, or upgrading the Tank, or taking Corrective Action, including, but not limited to the design, construction, monitoring, operation or maintenance requirements adopted pursuant to Health and Safety Code sections 25284.1 and 25292.4.

(q) "Project Tank" means the Tank concerning which the Project will occur.

(r) "Small Business" means a business which complies with all of the following:

(1) the principal office is located in California;

(2) the officers of the business are domiciled in California;

(3) it is independently owned and operated;

(4) it is not dominant in its field of operation; and

(5) its annual receipts are in an amount less than the limits established by Government Code Section 11342.610.

(s) "Surplus Money Investment Fund" means the fund established by Government Code Section 16471.

(t) "Tank" means an Underground Storage Tank used for the purpose of storing Petroleum.

(u) "Underground Storage Tank" means:

(1) a tank and connected piping, which is substantially or totally beneath the surface of the ground, except:

(A) A tank holding 1,100 gallons or less which is located on a farm, and which stores motor vehicle fuel used primarily for agricultural purposes, and not for resale; or

(B) A tank which is located on a farm or at the residence of a person which has a capacity of 1,100 gallons or less, and which stores home heating oil for consumptive use on the premises where stored; or

(C) Structures such as sumps, separators, storm drains, catch basins (except as discussed in subsection (u)(2), oil field gathering lines, refinery pipelines, lagoons, evaporation ponds, well cellars, separation sumps, lined and unlined pits, sumps and lagoons; and

(2) under dispenser containment systems, spill containment systems, enhanced monitoring and control systems, and vapor recovery systems and dispensers connected to the tank and connected piping.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.10, 15399.12, 15399.14, 15399.15, 15399.15.1 and 15399.15.2, Government Code.

HISTORY

1. New section filed 2-8-90 as an emergency; operative 2-8-90 (Register 90, No. 7). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed by operation of law on 8-7-90.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 13).
3. New section filed 2-25-91 as an emergency; operative 2-25-91 (Register 91, No. 13). A Certificate of Compliance must be transmitted to OAL by 8-26-91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2-25-91 order including amendment of subsections (h), (o) and (s) transmitted to OAL 5-24-91 and filed 6-24-91 (Register 91, No. 40).
5. Change without regulatory effect amending chapter heading and subsection (k) filed 2-7-94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
6. Amendment of subsection (n), redesignation and amendment of former subsections (s)-(s)(3) to subsections (s)(1)(A)-(C), new subsection (s)(2) and amendment of NOTE filed 1-3-2000 as an emergency; operative 1-3-2000 (Register 2000, No. 1). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 7-3-2000 or emergency language will be repealed by operation of law on the following day.
7. Reinstatement of section as it existed prior to 1-3-2000 emergency amendment by operation of Government Code section 11346.1(f) (Register 2000, No. 31).
8. Amendment of section and NOTE filed 9-5-2000 as an emergency; operative 9-5-2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3-5-2001 or emergency language will be repealed by operation of law on the following day.
9. Amendment of subsections (i) and (u)(1)(C) filed 10-16-2000; operative 10-16-2000 pursuant to Government Code section 11343.4(d) (Register 2000, No. 42).
10. Editorial correction of HISTORY 8 (Register 2001, No. 10).
11. Amendment of section and NOTE refiled 3-6-2001 as an emergency; operative 3-6-2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9-4-2001 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 3-6-2001 order, including further amendment of first paragraph and subsections (h) and (r)(5), transmitted to OAL 8-3-2001 and filed 9-17-2001 (Register 2001, No. 38).

§ 5901. Eligibility.

(a) An Applicant shall be eligible for a Loan when the Office determines all of the following:

(1) The Applicant is an existing Small Business which owns or operates one or more Project Tanks.

(2) No similar financing is available to the Applicant. A determination that no similar financing is available shall consist of one of the following:

(A) The Office makes a finding that the Applicant is unlikely to obtain a Loan to fund the Project from private financial institutions, the Hazardous Substance Cleanup Financing Authority, the California Pollution

Control Financing Authority, or other government agencies, under terms and conditions substantially similar to a loan.

(B) The Office locates alternative financing sources for the Applicant, and the Applicant submits evidence that these financing sources are unwilling to finance the Project on terms and conditions substantially similar to those available with a Loan.

(3) The Applicant has complied with, is exempt from, or is not currently subject to, the Financial Responsibility requirements specified in section 25299.31 of the Health and Safety Code and implementing regulations.

(4) The Project is located in California.

(5) All Tanks owned or operated by Applicant have a current Permit or are exempt from the permit requirements, pursuant to Health and Safety Code section 25283.5.

(b) An Applicant shall be eligible for a Grant, if the Applicant owns or operates one or more Project Tanks and meets the requirements set forth in Government Code section 15399.15(a).

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.11, 15399.12, 15399.15, 15399.15.1 and 15399.15.2, Government Code.

HISTORY

1. New section filed 2–8–90 as an emergency; operative 2–8–90 (Register 90, No. 7). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed by operation of law on 8–7–90.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 13).
3. New section filed 2–25–91 as an emergency; operative 2–25–91 (Register 91, No. 13). A Certificate of Compliance must be transmitted to OAL by 8–26–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–25–91 order including amendment transmitted to OAL 5–24–91 and filed 6–24–91 (Register 91, No. 40).
5. Amendment of section and NOTE filed 9–5–2000 as an emergency; operative 9–5–2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3–5–2001 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2001, No. 10).
7. Amendment of section and NOTE refiled 3–6–2001 as an emergency; operative 3–6–2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9–4–2001 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3–6–2001 order, including further amendment of subsection (b), transmitted to OAL 8–3–2001 and filed 9–17–2001 (Register 2001, No. 38).

§ 5902. Loan Terms.

(a) In addition to the Loan terms established by Government Code section 15399.14, each Loan Agreement shall include the following terms and conditions:

(1) A description of security and collateral for the Loan and conditions pertaining thereto, as determined by the Office, and agreed to by the Applicant.

(2) A provision that the Borrower shall pay late charges in the event of a default.

(3) An affirmative covenant by the Borrower that it shall continuously comply with any applicable federal, state, or local requirement, including requirements for operating Underground Storage Tanks throughout the term of the Loan.

(4) An agreement that all work funded with Loan proceeds shall be performed by a licensed contractor as defined in title 10, California Code of Regulations, section 5250(i).

(b) Disbursements shall be in stages, and each stage shall require conditions precedent to disbursement. The stages, and conditions precedent to disbursement for each stage, are as follows:

(1) If the Borrower is removing the Project Tank, disbursement is conditioned on:

(A) Providing to the Office an executed contract for removal by a licensed contractor with costs consistent with the Project budget contained in the Loan Agreement; and

(B) A valid Permit issued by the Local Agency authorizing removal of the Project Tank.

(2) If the Borrower is upgrading the Project Tank, disbursement is conditioned on:

(A) An executed contract for upgrading the Tank by a licensed contractor with costs consistent with the Project budget contained in the Loan Agreement;

(B) A valid Permit issued by the Local Agency authorizing removal of the Project Tank if removal is part of the Project; and

(C) A copy of the Local Agency authority to close the Tank site if closure is part of the Project.

(3) If the Project is Tank replacement, disbursement is conditioned on providing to the Office:

(A) An executed contract for removal of the old Tank and placement of a new Tank by a licensed contractor with costs consistent with Project budget contained in the Loan Agreement;

(B) A valid Permit issued by the Local Agency authorizing removal and replacement of the Tank; and

(C) A copy of the Local Agency authority to close the Tank site if closure is part of the Project.

(4) If the Project is to take Corrective Action; disbursement is conditioned on providing to the Office:

(A) An executed contract for Corrective Action by a licensed contractor with costs consistent with Project budget contained in the Loan Agreement; and

(B) A valid Permit issued by the Local Agency for the Project.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Section 15399.14, Government Code.

HISTORY

1. New section filed 2–8–90 as an emergency; operative 2–8–90 (Register 90, No. 7). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed by operation of law on 8–7–90.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 13).
3. New section filed 2–25–91 as an emergency; operative 2–25–91 (Register 91, No. 13). A Certificate of Compliance must be transmitted to OAL by 8–26–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–25–91 order including amendment of subsection (b) transmitted to OAL 5–24–91 and filed 6–24–91 (Register 91, No. 40).

§ 5903. Application Availability and Completion Review.

(a) Applications shall be available from, and the Applicant shall submit one (1) signed copy of all information requested in the Application to the following address: Technology, Trade and Commerce Agency, Office of Small Business, 1017 J Street, Sacramento, California 95814, Attention: RUST Program.

(b) The Office shall review each Application to determine whether the Application is complete. No later than ten (10) days following receipt of a Loan Application and no later than thirty (30) days following receipt of a Grant Application, the Office shall either:

(1) Send a letter to the Applicant indicating that the Application is incomplete and specifying the steps, if any, which the Applicant must take to correct identified deficiencies; or

(2) Send a letter to the Applicant indicating that the Application is complete.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.11, 15399.15, 15399.15.1 and 15399.15.2, Government Code.

HISTORY

1. New section filed 2–8–90 as an emergency; operative 2–8–90 (Register 90, No. 7). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed by operation of law on 8–7–90.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 13).
3. New section filed 2–25–91 as an emergency; operative 2–25–91 (Register 91, No. 13). A Certificate of Compliance must be transmitted to OAL by 8–26–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–25–91 order transmitted to OAL 5–24–91 and filed 6–24–91 (Register 91, No. 40).

5. Change without regulatory effect amending subsection (a)(1) filed 2–7–94 pursuant to title 1, section 100, California Code of Regulations (Register 94, No. 6).
6. Amendment of section and NOTE filed 9–5–2000 as an emergency; operative 9–5–2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3–5–2001 or emergency language will be repealed by operation of law on the following day.
7. Editorial correction of HISTORY 6 (Register 2001, No. 10).
8. Amendment of section and NOTE refiled 3–6–2001 as an emergency; operative 3–6–2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9–4–2001 or emergency language will be repealed by operation of law on the following day.
9. Certificate of Compliance as to 3–6–2001 order, including further amendment of subsection (a), transmitted to OAL 8–3–2001 and filed 9–17–2001 (Register 2001, No. 38).

§ 5904. Loan Application Content.

A completed Application for a Loan shall consist of all of the following:

(a) The name, address and telephone number of the Applicant, the name and title of Applicant's principal contact person, a description of Applicant's type of business and the date the Applicant's business was established. For any Application where a business or individual proposes to guarantee the Loan repayment, the Application shall include information concerning the proposed guarantors, including current financial statements and tax returns for the previous two years, and a list of information concerning each guarantor, including his or her name, address, phone numbers, employer and amount of time at current residence and employment.

(b) Evidence that each Tank owned or operated by the Applicant has a current Permit issued to the Applicant, or the Applicant shall explain why a Tank which it owns or operates is exempt from the Permit requirements. Evidence of a current Permit shall consist of one of the following:

(1) Copy of a current Permit issued by the Local Agency; or

(2) Both of the following:

(A) A completed Application to operate an Underground Storage Tank in the form utilized by the State Water Resources Control Board, and described at section 2711 of title 23, California Code of Regulations, signed by an authorized representative of the Local Agency; and

(B) Evidence that the permit fee has been paid for each Underground Storage Tank owned or operated by the Applicant for the current year, consisting of a canceled check or a receipt from the Local Agency.

(c) A list of all Underground Storage Tanks owned or operated by Applicant, including the street address of each Underground Storage Tank.

(d) A description of any unauthorized releases from any Underground Storage Tanks owned or operated by the Applicant, including copies of correspondence with the Local Agency, and reports made to insurers.

(e) Information regarding the Project for which funding is being requested, including:

(1) An explanation of the reasons the Project Tank is not in compliance with applicable federal, state or local standards or will not be in compliance with federal, state or local standards in the future;

(2) A description of the Project to be completed including an estimated timetable for completion of the Project;

(3) The reasons Applicant believes that, upon completion of the Project, the Project Tank will comply with federal, state and local standards;

(4) Project components and cost estimates, including the name and applicable experience of the individual or firm preparing the cost estimates, and copies of any supporting invoices, estimates or contracts; and

(5) Identification of any required federal, state or local permits necessary to carry out the Project.

(f) If the Project includes Corrective Action, the following:

(1) A description, budget and timeline for each segment or activity comprising the Corrective Action, and the identified source of funding, including the Loan, for each segment or activity; and

(2) A copy of any Corrective Action plan filed with a public agency.

(g) Information and documents demonstrating that the Applicant is able to provide adequate collateral and repay the Loan, including, if available, tax returns, personal and business financial statements, history of insolvency, status of any tax audits or lawsuits and the existence and solvency of any guarantors.

(h) Loan amount requested and the term of the Loan.

(i) Applicant's current financial statement and, if available, the financial statements for the previous two (2) years.

(j) Evidence that the Applicant has complied with applicable federal or state laws pertaining to Financial Responsibility. In the alternative, the Applicant shall certify that it is exempt from Financial Responsibility requirements because the only Underground Storage Tanks owned by Applicant will be removed as part of the Project, or that Financial Responsibility requirements do not currently apply to the Underground Storage Tanks, specifying reasons.

(k) A copy of any application filed with any public agency to obtain the permit(s) necessary to construct the Project.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.11, 15399.12 and 15399.13, Government Code.

HISTORY

1. New section filed 2–8–90 as an emergency; operative 2–8–90 (Register 90, No. 7). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed by operation of law on 8–7–90.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 13).
3. New section filed 2–25–91 as an emergency; operative 2–25–91 (Register 91, No. 13). A Certificate of Compliance must be transmitted to OAL by 8–26–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–25–91 order including amendment of subsection (a) transmitted to OAL 5–24–91 and filed 6–24–91 (Register 91, No. 40).
5. Amendment of section heading and first paragraph filed 9–5–2000 as an emergency; operative 9–5–2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3–5–2001 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2001, No. 10).
7. Amendment of section heading and first paragraph refiled 3–6–2001 as an emergency; operative 3–6–2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9–4–2001 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3–6–2001 order transmitted to OAL 8–3–2001 and filed 9–17–2001 (Register 2001, No. 38).

§ 5904.1. Grant Application Content.

The RUST Grant Application Form (5/29/2001), incorporated by reference) shall consist of the following items:

(a) A description of the Applicant's business, including the business' name, telephone number, street address, city, state, zip code, county, federal employer identification number or social security number of the primary owner, North American Industry Classification System (NAICS) code, and the number of full– and part–time workers employed by the business. A person working fewer than forty (40) hours a week shall be considered a part–time employee. The application form shall also include the following statement: "If a Federal Employer Identification Number is unavailable, a social security number is required. Pursuant to the Federal Privacy Act of 1974, you are hereby notified that it is mandatory to provide your Social Security Number. The social security number will be used by the Agency solely for the purpose of identifying the recipient of the Grant funds."

(b) The amount of Grant funding requested. The minimum amount of Grant funding an Applicant shall apply for is ten thousand dollars ($10,000). The maximum amount of Grant funding an Applicant shall apply for is fifty thousand dollars ($50,000).

(c) The names and addresses of each owner and corporate officer of the Applicant. (If an owner is a corporate entity, list the name and business address of its principle place of business.)

(d) A description of the Project the Applicant will finance with the Grant, including a list of all Tanks to be improved with the Funds from this Grant, and a time–table for the completion of the Project.

(e) An estimate of the cost of the Project, including the name and applicable experience of the individual or firm preparing the estimate; supporting documentation (such as invoices, bids, or contracts); and a list of the materials necessary to complete the Project.

(f) A statement indicating if the Applicant has owned all Underground Storage Tanks included in subsection (d) between January 1, 1997 and the date of the Application. If the answer is no, list the name of any person or entity owning any of the tanks during that time, and the relation, if any, of the persons or entities to the Applicant.

(g) A list of all Underground Storage Tanks located in California owned and operated by Applicant other than those listed in subsection (d).

(h) The Applicant shall indicate if they acquired debt to upgrade the Underground Storage Tanks listed in subsections (d) and and/or (g). If yes, the Applicant shall provide evidence of the debt, e.g. the note or loan agreement.

(i) The Applicant shall indicate if they sold less than 900,000 gallons of gasoline at retail annually for each of the two years preceding the submission of this application.

(j) The Applicant's most recent employee tax return form (IRS Form 941 or EDD form DE–6)

(k) The Applicant's most recent California Tax Return (FTB Form 530)

(*l*) Schedule G, Fuel Seller's Supplement to Sales and Use Tax Return Forms (SBE Form 401, rev 49, 7–99) submitted by the Applicant to the State Board of Equalization during the last eight (8) quarters.

(m) An Underground Storage Tank Facility Upgrade Compliance Certificate with an issue date of January 1, 1999 or earlier for each Tank identified in subsection (d). If the certificate was issued after January 1, 1999, the Applicant shall enclose a letter from the local agency that issued the certificate stating that the Applicant's business was in compliance with federal and state Underground Storage Tank requirements prior to January 1, 1999.

(n) The current operating permit for each Underground Storage Tank identified in subsection (d).

(o) A certification signed and dated by the Applicant. The certification shall include the following language: I hereby certify, under penalty of perjury under the laws of the State of California, that the information provided in this Application is true and correct and represents the intended use of all sources of funds identified in the Application, and that I will inform the California Technology, Trade and Commerce Agency immediately of any changes therein.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.15, 15399.15.1 and 15399.15.2, Government Code.

HISTORY

1. New section filed 9–5–2000 as an emergency; operative 9–5–2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 10).
3. New section refiled 3–6–2001 as an emergency, including further amendments; operative 3–6–2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9–4–2001 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–6–2001 order, including further amendment of section, transmitted to OAL 8–3–2001 and filed 9–17–2001 (Register 2001, No. 38).

§ 5905. Loan Application Process.

(a) Upon receipt by the Office of the completed Application, the Office shall approve a request for a Loan when it finds all of the following requirements are met:

(1) The Applicant has applied for all permits necessary to complete the Project;

(2) The business is creditworthy;

(3) Any Environmental Audit supports, or does not materially adversely affect, the decision to make the Loan;

(4) Collateral and the source of repayment are sufficient for the proposed Loan; and

(5) Funds are available to meet the funding request.

(b) Where any of the conditions and requirements of this section have not been met, the Office shall deny the Application and determine what specific actions, if any, the Applicant must take to obtain further Office evaluation and review of the Application.

(c) No later than sixty (60) days from the date upon which the Office notified the Applicant that the Application is complete, the Office shall notify the Applicant of the Office's Loan decision, along with any explanation required by subsection (b) above.

(d) If the Office approves the Loan, then the Office shall be authorized to enter into a Loan Agreement which embodies the terms specified in section 5902 and any other items agreed to by the Applicant and Office.

(e) If the Office denies the Application, the Applicant shall have no right to administratively appeal the decision, but may reapply at any time.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.12, 15399.13, 15399.14 and 15399.15, Government Code.

HISTORY

1. New section filed 2–8–90 as an emergency; operative 2–8–90 (Register 90, No. 7). A Certificate of Compliance must be transmitted to OAL within 180 days or emergency language will be repealed by operation of law on 8–7–90.
2. Repealed by operation of Government Code section 11346.1(g) (Register 91, No. 13).
3. New section filed 2–25–91 as an emergency; operative 2–25–91 (Register 91, No. 13). A Certificate of Compliance must be transmitted to OAL by 8–26–91 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 2–25–91 order transmitted to OAL 5–24–91 and filed 6–24–91 (Register 91, No. 40).
5. Amendment of section heading and subsection (a) filed 9–5–2000 as an emergency; operative 9–5–2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3–5–2001 or emergency language will be repealed by operation of law on the following day.
6. Editorial correction of HISTORY 5 (Register 2001, No. 10).
7. Amendment of section heading and subsection (a) refiled 3–6–2001 as an emergency; operative 3–6–2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9–4–2001 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3–6–2001 order transmitted to OAL 8–3–2001 and filed 9–17–2001 (Register 2001, No. 38).

§ 5906. Grant Application Process; Funding Determination.

(a) The Agency shall fund all eligible, complete Grant Applications in the order received.

(b) Subsequent to the award of a Grant, and prior to the payment of the Grant award, the Applicant shall enter into a Grant Agreement with the Office.

NOTE: Authority cited: Section 15399.16, Government Code. Reference: Sections 15399.11, 15399.12 and 15399.13, Government Code.

HISTORY

1. New section filed 9–5–2000 as an emergency; operative 9–5–2000 (Register 2000, No. 36). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 3–5–2001 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 2001, No. 10).
3. New section refiled 3–6–2001 as an emergency, including further amendments; operative 3–6–2001 (Register 2001, No. 10). Pursuant to Government Code section 15399.16, a Certificate of Compliance must be transmitted to OAL by 9–4–2001 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 3–6–2001 order, including further amendment of section, transmitted to OAL 8–3–2001 and filed 9–17–2001 (Register 2001, No. 38).

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Title 10. Investment

Chapter 8. California Industrial Development Financing Advisory Commission

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Chapter 8. California Industrial Development Financing Advisory Commission

Article 1. General Provisions

§ 6000. Objectives.

Pursuant to the California Industrial Development Financing Act, it is the policy of the state, consistent with environmental, resources conservation and other policies, to provide through the issuance of revenue bonds an alternative method of financing in acquiring, construction, or rehabilitating industrial and energy development facilities in accordance with the criteria set forth in Section 91502.1 of the Act, all to the mutual benefit of the people of the state and to protect their health, welfare and safety.

NOTE: Authority cited: Section 91557, Government Code. Reference: Section 91401 and 91502.1, Government Code.

HISTORY

1. New Chapter 8 (Articles 1–3, Section 6000–6070, not consecutive) filed 11–20–81 as an emergency; effective upon filing (Register 81, No. 49). For history of former Chapter 8 "Secretary of State," see Register 77, No. 36.
2. Order of Repeal of 11–20–81 emergency order filed 11–30–81 by OAL pursuant to Government Code Section 11349.6 (Register 81, No. 49).
3. New Chapter 8 (Articles 1–3, Section 6000–6070, not consecutive) filed 12–22–81 as an emergency; effective upon filing. Certificate of Compliance included (Register 82, No. 1)

Article 2. Definitions

§ 6010. Terms.

The words and terms defined in Section 91504 of the Act shall have the same meaning when used in these Regulations. The following additional terms shall be used in the manner described below:

(a) "Act" means the California Industrial Development Financing Act, Title 10, commencing with Section 91500 et seq. of the Government Code.

(b) "Commission" means the California Industrial Development Financing Advisory Commission, also referred to in the Act as the "State Office".

(c) "Applicant" is a company as defined in Section 91504 of the Act which has submitted to the Commission an application approved by a public agency.

(d) "Chairperson" is the chairperson of the Commission, designated in the Act as the state Treasurer, or his/her designee.

(e) "Bonds" includes refunding bonds in addition to the meanings as defined in Section 91504(e) of the Act.

NOTE: Authority cited: Section 91557, Government Code. Reference: Sections 91504, 91531 and 91561, Government Code.

Article 3. Actions

§ 6040. Authority Reports.

(a) Each Authority, upon approval by the public agency of the ordinance creating the Authority, shall send to the Commission a certified copy of said ordinance as well as a list of the members of the board, officers and executive employees and designate the person(s) and an address and phone number to be contacted concerning the business of the authority.

(b) The Authority will promptly notify the Commission of all changes in the information provided in Section (a) above.

NOTE: Authority cited: Section 91557, Government Code. Reference: Sections 91520, 91524 and 91563, Government Code.

§ 6050. Submission of Project Information.

(a) An Authority shall not issue bonds for a project until the information referenced in Section 91531 of the Act has been received by the Commission and the determination required under said section have been made by the Commission or the Authority.

(b) For a period of sixty (60) days following the date of receipt by the Commission of the information referenced in Section 91531 the Commission shall have sole jurisdiction to make the determinations required by said section provided that the sixty day period may be extended by written consent of the Authority. At the end of sixty days, if that period has not been extended by the written consent of the Authority, and the Commission has not made its required determinations, the Commission shall lose jurisdiction to make such determinations.

(c) The nature of the information required for the making of the determination pursuant to Section 91531 is as follows:

(1) The application submitted by an applicant to an Authority and approved by the public agency which application shall minimally include:

(A) Identification of and a description of the applicant.

(B) A description of the project.

(C) A description of the activities or uses for which property acquired as part of the undertaking of the project will be suitable.

(D) The cost of the project.

(E) The maximum amount of bonds proposed to be issued in conjunction with the undertaking of the project.

(F) A description of the proposed issuance of bonds including security therefor, the revenues to be used in paying debt service and whether the bonds are proposed to be issued in exchanged for one or more outstanding bonds or bonds, or claims, or partly in such exchange and partly for cash or property.

(G) A description of the public benefit, pursuant to criteria contained in Section 91502.1, which would accrue from undertaking the project.

(H) A description of any public detriment from issuance of bonds in the maximum amount proposed in the application.

(I) A description of the statewide size and location of the operations of the applicant both at the time of the application and as projected following completion of the project.

(J) Information as to whether the completion of the project or operation of facilities to be acquired as part of the undertaking of the project is reasonably necessary to prevent the relocation of any substantial operations of a company from an are within the state to an area outside the state.

(K) Any other information deemed by the applicant or the Authority to be necessary to the accurate portrayal of the project and its effects or which would facilitate the determination required by Sections 91530 and 91531.

(2) The identification of the Authority which accepted the application and the public agency which approved said application.

(3) Certified copies of all resolutions and other documents relating to actions taken by the authority and the public agency with regard to the application.

NOTE: Authority cited: Section 91557, Government Code. Reference: Section 91531, Government Code.

§ 6060. Receipt, Review and Determinations.

(a) The date of receipt of project information by the Commission shall be the date when information of the nature described in Section 6050(c) of this Article sufficient to enable Commission determinations pursuant to Section 91531 of the Act has been received.

(b) The Commission shall notify the applicant and the Authority in writing of the date of receipt of project information not later than seven (7) days after the arrival of the project information at the office of the Commission.

(c) The Commission shall review the project information as necessary to determine the compliance of the project with the criteria set forth in Section 91531. The Commission may, however, with regard to the determination of project compliance with the criteria specified in paragraph (b) (3) of Section 91531, accept certifications made by the Authority

submitting the project information, bond counsel, purchaser, or such other certifications as the Commission may require for the proposed issuance of bonds in conjunction with the undertaking of he project.

(d) The Commission shall, on the basis of its review of the submitted project information, make express findings in writing as to its determination of the compliance of a project with the criteria set forth in Section 91531.

(e) With regard to the determination, identified in Section 91531(b)(3) the Commission may impose a condition or conditions on qualification of a proposed issuance of bonds if it finds that without such condition(s) the issuance will be unfair, unjust or inequitable to a purchaser of the bonds.

(f) Written notification of the determinations of the Commission shall be given to the Authority and the applicant which submitted the project information. The Commission may, if requested by the Authority submitting the project information (which request shall be accompanied by a written approval of the extension of the period of Commission jurisdiction in making the determinations required by Section 91531), delay the provision of a finding regarding compliance with the criterion set forth in Section 91531(b)(3) until such time as will facilitate the Authority's proposed issuance of bonds.

(g) Determinations of the Commission with regard to project compliance with criteria set forth in Section 91531 shall be final and conclusive.

(h) Having made its Determinations, conditionally or otherwise, the Commission will not suspend or revoke any qualification of the bonds, once the bonds have been sold, absent extraordinary circumstances.

(i) In addition to the other requirements of the Act, the Commission in reviewing Applications for Financing may take into consideration such factors as: location of the proposed project; nature of the proposed project; time of receipt of request for financing; and any other factors the Commission may deem appropriate. Priority shall be given to projects which achieve maximum realization of public benefit.

NOTE: Authority cited: Section 91557, Government Code. Reference: Sections 91501, 91531 and 91536, Government Code.

§ 6070. Fees.

The Commission shall charge fees commensurate with its direct expenses and those of the State Treasurer.

(a) The minimum fee for each applicant submitted with each application shall be one thousand two hundred fifty dollars ($1,250).

(b) The general fee shall be one quarter of one percent (.0025) of the total amount of the bonds issued for bonds up to a maximum of $10 million. For bonds issued above $10 million and up to $20 million, the general fee shall be twenty–five thousand dollars ($25,000.00). For bonds issued over $20 million, the general fee shall be negotiated, to cover any additional direct expenses that may be incurred by the Commission, but in no event shall the general fee be less than twenty–five thousand dollars ($25,000.00). The general fee shall be payable within ten (10) days after delivery of the bonds. The general fee shall be in addition to the minimum application fee of one thousand two hundred fifty dollars ($1,250).

NOTE: Authority cited: Section 91553, Government Code. Reference: Section 91553, Government Code.

HISTORY

1. Amendment filed 12–29–82 designated effective 1–1–83 pursuant to Government Code Section 11346.2(d) (Register 83, No. 1).
2. Amendment filed 7–25–88; operative 7–25–88 (Register 88, No. 33).
3. Amendment of subsections (a) and (b) filed 7–2–2002; operative 7–2–2002 pursuant to Government Code section 11343.4 (Register 2002, No. 27).

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Chapter 9. California Export Finance Office of the California State World Trade Commission

Article 1. General Provisions

§ 6110. Locations of Offices.

NOTE: Authority cited: Section 15349.1, Government Code. Reference: Section 15349.1, Government Code.

HISTORY

1. New chapter 9 (sections 6110–6150) filed 5–4–92; operative 6–3–92 (Register 92, No. 20).
2. Change without regulatory effect repealing chapter (articles 1–2, sections 6110–6150), article 1 (sections 6110–6120) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6120. Definitions.

NOTE: Authority cited: Section 15394.1, Government Code. Reference: Section 15394.1, Government Code.

HISTORY

1. New section filed 5–4–92; operative 6–3–92 (Register 92, No. 20).
2. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

Article 2. Eligibility Criteria and Application Procedure

§ 6130. Eligibility Criteria and Standards.

NOTE: Authority cited: Section 15394.1, Government Code. Reference: Section 15394.1, Government Code.

HISTORY

1. New section filed 5–4–92; operative 6–3–92 (Register 92, No. 20).
2. Change without regulatory effect repealing article 2 (sections 6130–6150) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6140. Application Procedure.

NOTE: Authority cited: Section 15394.1, Government Code. Reference: Section 15394.1, Government Code.

HISTORY

1. New section filed 5–4–92; operative 6–3–92 (Register 92, No. 20).
2. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6150. Application Review Process.

NOTE: Authority cited: Section 15394.1, Government Code. Reference: Section 15394.1, Government Code.

HISTORY

1. New section filed 5–4–92; operative 6–3–92 (Register 92, No. 20).
2. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

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Chapter 10. Trade and Commerce Agency: Job Creation Investment Fund Grant Program

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§ 6200. Definitions.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Sections 15365.50 and 15365.54, Government Code.

HISTORY

1. New chapter 10 (sections 6200–6207) and section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).
3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New chapter 10 (sections 6200–6207) and section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing chapter (sections 6200–6207) and section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6201. Eligible Uses of Grant Funds.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Section 15365.55, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).
3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6202. Job Creation Investment Fund Grant Process.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Section 15365.55, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).
3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6203. Resolution Content.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Section 15365.55, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).
3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6204. Application Content.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Sections 15365.53 and 15365.55, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).
3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6205. Job Creation Plan Content.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Sections 15365.53, 15365.55 and 15365.56, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).
3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6206. Eligible Application.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Section 15365.55, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of HISTORY 1 (Register 98, No. 40).

3. Repealed by operation of Government Code section 11346.1(g) (Register 98, No. 40).
4. New section filed 9–28–98 as an emergency; operative 9–28–98 (Register 98, No. 40). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 3–29–99 or emergency language will be repealed by operation of law on the following day.
5. Repealed by operation of Government Code section 11346.1(g) (Register 2000, No. 19).
6. New section filed 5–11–2000; operative 6–10–2000 (Register 2000, No. 19).
7. Change without regulatory effect repealing section filed 12–26–2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 52).

§ 6207. Funding Determination.

NOTE: Authority cited: Section 15365.58, Government Code. Reference: Section 15365.55, Government Code.

HISTORY

1. New section filed 11–6–97 as an emergency; operative 1–1–98 (Register 97, No. 45). Pursuant to Government Code section 15365.58 and Stats. 1997, chapter 270, section 183, a Certificate of Compliance must be transmitted to OAL by 6–30–98 or emergency language will be repealed by operation of law on the following day.
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